Report on the proceedings of the 2nd Annual

Clinical Education Symposium

Department of Physical Therapy
The University of British Columbia

February 3, 2012

Carey Centre, UBC Campus

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Physical Therapy
UBC

FACULTY OF MEDICINE

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Agenda

Segment	Speaker(s)	Start	End
• **Welcome** • **"Looking Back, Looking Forward"**	Sue Murphy	9:00	9.30
What's New in UBC PT Clinical Education	Sue Murphy	9:30	10:30
Northern and Rural Cohort	Robin Roots	9:35	9:55
HSPnet student matching	Ingrid Dill	9:55	10:10
APP vs. CPI	Megan Dalton	10:10	10:25
Morning Coffee Break – Carey Caf		*10:30*	*11:00*
"Concurrent Session Dialogues Participants will choose ***two of four*** concurrent sessions and work in facilitated small groups to identify key issues around the current PT Clinical Education practice in BC. Ideas and directions for the future will be generated by these discussions. • *Communications and liaison with the clinical community - how are we doing?* • *HSPnet and student placements organization – do you really know how it all works?* • *Student professionalism and readiness for placement and practice* • *Building capacity – Innovative models and new directions*	Group discussions	11:00	12:00
Tech time! *The times are always changing, especially when it comes to technology.* *Here are two of our latest 'techy ventures."*		12:00	12:45
***T-Res* overview**	Carolyn Andersson	12:00	12:20
***Virtual Patient Project* demonstration**	Joseph Anthony	12:20	12:40
Lunch – Carey Caf		*12:45*	*1:30*
Pop Quiz *Test your knowledge of all things ClinEd for the chance to win prizes!*		1:30	1:45
"World Café" *Discussions and input regarding current ClinEd issues*	Group discussions	1:45	2:45
"World Café" Summary	Sue Murphy	2:45	3:00
Afternoon Coffee Break – Carey Caf		*3:00*	*3:15*
Key Priorities: What do we need to focus on?	Sue Murphy	3:15	3:45
Evaluation and closing remarks		3:45	4:00

Report on the Proceedings of the 2nd UBC MPT CLINICAL EDUCATION SYMPOSIUM

UBC Department of Physical Therapy
February 3, 2012

The 2nd UBC MPT Clinical Education Symposium was held on February 3, 2012, three and a half years since the initial event. The day consisted of a mix of interactive activities, presentations and discussion, and was very well received by all who attended. These proceedings will provide an overview of the day, as well as action items and discussion of future directions for the Clinical Education portfolio.

Participants

Participants included representatives from all health authorities in the province from a wide range of practice areas and portfolios, as well as faculty and invited guests from CPTBC and PABC. It was unfortunate that despite significant efforts from UBC, no private practice practitioners were able to attend. (For a complete list of participants see *Appendix 6*).

Looking back, looking forward

Sue Murphy began with an overview of the day and a presentation on "Looking Back, Looking Forward" (see *Appendix 1*) which highlighted action taken since the last symposium, progress made and issues still outstanding.

Following Sue's presentation, Ingrid Dill gave an overview of the automated student matching, Robin Roots introduced the Northern and Rural Cohort program, and Megan Dalton discussed the APP form.

All presentations were very well received. Discussion identified several current needs including the need to build a culture of clinical education (with supervising students being the norm), the need to educate managers about the benefits of clinical education for the organization, the need to replace the current evaluation form, and the need to define what placements in "geriatric" and "Interprofessional" areas really encompass (for full discussion details, see *Appendix 2*).

Concurrent Sessions

Participants were asked to choose two of four possible concurrent sessions for small group discussion. The four question themes were:

1) Communications and liaison with the clinical community: How are we doing?
2) HSPnet and student placements organization: Do you really know how it all works?
3) Student professionalism and readiness for placement and practice
4) Building capacity: Innovative models and new directions

There was excellent discussion in all groups and many ideas were generated (see *Appendix 3*). Major themes which emerged included the ongoing issue of preceptor recognition, suggestions to further improve communication, the need for increased visibility of the UBC Clinical Education team, and the need to explore new and different clinical practice areas to build capacity.

Tech Time

Carolyn Andersson presented an overview of the new T-Res System for the student 's clinical logging, and Sue Murphy gave an overview of the reports and data which could be generated from the system. Joseph Anthony then gave an overview of the "Virtual Patients" project and demonstrated two of the on-line cases. Both presentations engendered much discussion and interest.

Quiz!

Carolyn Andersson presented a fun and challenging quiz for attendees that had everyone guessing what languages Carolyn and Ingrid speak and what Sue recently did in her spare time!

World Café Discussions

Attendees participated in a "world café" style discussion, rotating around six discussion topics.

TOPIC 1: *"Interprofessional Learning" is becoming an increasingly important part of clinical education. It is likely that at times, PT students will be supervised by professions other than Physical Therapy. What are the advantages/disadvantages of this model and what guidelines (if any) should the Department put in place for these types of placements?*

It was felt that Interprofessional placements with non-PT supervision for part of the time were feasible and beneficial if carefully managed, offering increased breadth and depth of experience to the student. Key areas to be managed included where in the PT program the IP placements were located (i.e., Senior vs. Junior years, so that students had a better understanding of their profession) and the need to locate these placements in well-functioning teams with clear objectives and well trained preceptors who understood the goals of an Interprofessional Learning experience.

TOPIC 2: *We currently require non-Northern and Rural Cohort students to complete two "out-of-town" placements (at their expense). Is this the right amount of out-of-town experience? Should we require that they do more – or less – placements out of the Lower Mainland? Or should we let students decide whether they want to go on an out-of-town experience or not and remove the requirement?*

There was significant consensus that two "out of town" (OOT) placements was a good number for all students to complete. Again it was felt that OOT placements provide breadth and depth to the learning experience as well as helping students to develop coping and problem solving skills in situations which are challenging or where there are fewer resources. The need for communities to look at options for providing accommodation was also discussed.

TOPIC 3: *Should technology-enhanced learning be used to replace time spent in the clinical setting? There is increasing interest in the educational world in "simulated learning", which includes such activities as working with standardized clients, virtual/online cases, working with hi-fidelity manikins, etc. Could one of the current six placements – or part of one of those placements - be replaced by another form of technology-enhanced learning experience? Why or why not? And if yes, what should that experience be?*

There was general agreement that technology is a valuable adjunct to learning, particularly for the weak or struggling student, but that it should not replace clinical exposure. There was discussion around which types of learning could be best facilitated in a simulated model. Advantages noted were consistency of learning experience, and the ability to offer some simulation methods by distance. The need for authenticity in simulation was also noted.

TOPIC 4: *Sharing a student between two or more supervisors and clinical areas has advantages and disadvantages. It may increase capacity (some preceptors are more willing to take a student for part of the time than for a full placement) but is often more work to coordinate. What are some of the advantages and disadvantages of this model, should this be something the department is actively pursuing, and what "combos" of clinical areas might make the best partnerships?*

Overall, feedback for split placements was positive. Facilities that are currently providing split placements and having positive results are:

- Surrey Memorial (Acute/Community and Inpatient/Outpatient Neuro)
- Nanaimo Regional (Acute/Community)
- BCCH (has done five different clinics (one each day of the week) and rotate through this for five weeks.

Occupational Therapy students haves been participating in part-time placements for a while, including 4 days/week of clinical experience followed by a 5th day where a student works on an independent project. It was felt that this model could increase placement capacity (part- time clinicians could be involved, and full time clinicians may be more willing to supervise a student for part of the time), and could provide for interesting placement models (for example, following a patient through a variety of settings). Cons for this model included the potential for disjointed experiences, increased challenge for the student, and the additional time needed to coordinate evaluation of the student.

TOPIC 5: *Of all the graduate licensed physical therapists in BC, approximately half work in a private setting. However our students currently complete a maximum of 33% - and sometimes none - of their placements in a private setting. Should we increase the number of mandatory private practice placements?*

Unfortunately no clinicians from Private practice attended the symposium to debate this issue. The opinions of attendees were that the number of private practice placements should not be increased due to the limited breadth of skills available in this setting. The limited number of private practices willing to take students in this setting was also noted as a concern, and initiatives such as student- led programs/clinics, and public/private split placements were suggested to build capacity. It was also noted that private practice placements should include the "business" side of the practice as well as hands-on treatment. Much discussion centered on improving the profile of public practice so that students were more likely to work in the public sector after graduation.

TOPIC 6: *Students are currently required to complete one placement in each of the following areas: Acute Care, Rehab, Outpatient, Geriatric or Community, and Interprofessional (which includes Paediatrics), plus an elective of their choice if all other placements are successfully completed. Is this categorization of placements the optimal one? Does it provide a sufficient breadth/depth of clinical experience and is it easy for facilities/supervisors to classify their placement offers this way? Are there better ways to classify placement types?*

Participants noted that the *"Interprofessional"* designation is not useful, as multiple areas are interprofessional in nature. It was also thought that the "*Acute Care"* category is too broad – students may miss out on gaining experience in a particular skill set, and more than one acute care placement many be needed. Lack of consistency between the current category definitions was noted – for example, some are settings (e.g., community) and others are patient age group (e.g., geriatrics). A matrix format was proposed, to help ensure students have a broad experience.

For full discussion details and the matrix, see *Appendix 4*.

Key Priorities

At the end of the day, Participants were asked to choose one key initiative for the Clinical Education Team to work on for the next three years ("If we could only work on one thing, what it would be").

The Key priorities for participants were:

- Changing the evaluation form (41%)
- Ensuring student receive an appropriate mix of placements and continue to have a broad experience (35%)
- Preceptor communication/recognition (18%)
- Access to T-Res for preceptors/site (6%)

Discussion

The day provided an excellent forum for information sharing and discussion. Several themes and areas for further work were identified.

Building capacity

A significant issue in public practice is the apparent reluctance of unit managers to support students from professions other than nursing on their units. There is a perception that non-Physical Therapy managers do not always see the value in student placements and are, despite the very modest increase in pay received by a supervising therapist, reluctant to financially support them. Several participants expressed the need for UBC to liaise with managers and recruitment departments in the health authorities; however how to effectively do this is unclear.

The need to look outside traditional areas of practice to build capacity was highlighted. Examples of these areas include outreach programs, mental health, and clinics such as ortho/trauma. Having PT students and PTA students on placement together, and PT/OT students in the clinical setting at the same time, could also be capitalized on.

A clear message was received around the need to change the evaluation form in order to build capacity, as the current form is a disincentive for preceptors. This initiative is already in place.

Placement/Caseload mix

Throughout the day there was discussion around the mix of clinical settings and caseload which students should experience. There is a clear need to further define what the description of each area of practice includes and to rethink the "interprofessional" piece. The matrix idea suggested is very interesting and could possibly be incorporated into the current student clinical logging system (T-Res).

Communication

Effort to enhance communication between UBC and the clinical sites appear to have been successful and well received, particularly at the Practice Lead level. A disconnect between UBC and front line preceptors was noted however, which is of significant concern. The desire for more personal (including face to face) contact between UBC and preceptors was noted and needs to be addressed.

The notable absence of private practice representatives at the symposium illustrated the ongoing issues of engaging and communicating with PPs. The private practice perspective was conspicuously absent from the discussions, which was detrimental and hampered a "big picture" view of clinical education in this province. .

Significant thought needs to be given as to how to engage this important sector which may have an increasing role in providing future placements, especially as providing placements in the public sectors continues to become more challenging.

Preceptor Recognition

This was a theme at the last symposium and it appears little progress has been made, although the plaques issued by the Faculty of Medicine have been very well received. Simple ideas such as timely and personal emails thanking preceptors for their contributions were suggested, as well as other more tangible items.

Action items

Based on the discussion, ideas and suggestions the following action items were identified.

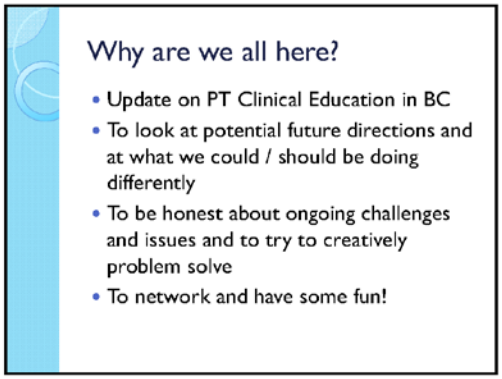
Issue	Action Item	Lead	Time frame
Private Practice			
Facilitating PP engagement and feedback: *1) Placements* *2) Input into activities/clin ed program*	Further discussion needed to determine strategy/future direction	Sue	Discussion and plan in place by Sept 2012
Communication			
Disconnect between preceptors and UBC	Email to preceptors and possibly students at the end of Week 2 and? Week 4 also. Automated thank-yous to clinical preceptors after placement and thank clinical sites which offered a placement which was not used. Immediately following placement have a teleconference with supervisors to get their feedback, impressions, positives/negatives opportunities for improvement	Sue Ingrid Sue	Start in Level 1 2012 Start in Level 1 2012
Email communications	Clin Ed Team preface each email subject as *"UBC PT:_____"*	Clin Ed Team	Immediately
Email Communications	Put appropriate web links in Clin Ed Team signatures (e.g.: Ingrid – HSPnet, Carolyn – Clin Ed Resource website section links)		Immediately
Newsletter	More highlights of PTs in community	Carolyn	Next Newsletter
Newsletter	A feature of one preceptor from the public sector and one from the private sector in each newsletter. Section called 'New site on board', introducing a new site taking students and/or also hi-lighting a site which has provided many preceptorships over the years.	Carolyn	Next newsletter
Visibility	Increase visibility of Clin Ed Team **Strategies needed – for further discussion amongst team**	Clin Ed Team	Discussion and plan in place by Sept 2012

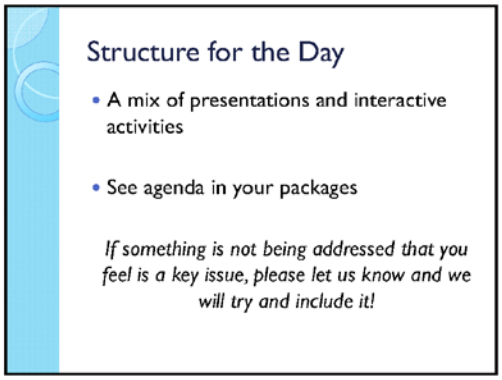
Issue	Action Item	Lead	Time frame
Preceptor Recognition			
Immediate thank you/appreciation after placement	Send out embedded email with graphics after preceptor has taken a student	Ingrid	Starting with Level 1 placements, 2012
Plaques	Continue with Plaques (Faculty of Medicine or Department)	Ingrid	Will depend on Faculty of Medicine time frame
Tokens of appreciation	Small tokens of appreciation **Strategies needed – for further discussion amongst team**	All to discuss – Carolyn to source – Ingrid to send	Discussion and plan in place by Sept 2012
Continuing education	Explore access to virtual cases for Preceptors	Sue	December 2012
Website			
People unaware of what is on website	Send out handout about Clin Ed section of website	Carolyn	Immediately
HSPnet			
Lack of familiarity with HSPnet, e.g.: How/where to enter preceptor information and descriptions	Develop orientation materials or handouts	Ingrid	December 2012
T-Res			
Access for sites/supervisors	Explore costs/feasibility	Sue	Dec 2012
Matrix to ensure broad range of skills/practice areas for students	Develop matrix and assess feasibility of adding to T-Res	Sue/All	Dec 2012
Placements			
Placement experience mix	Develop matrix and assess feasibility of adding to T-Res Define an Interprofessional placement and consider a more appropriate way to capture Interprofessional learning Encourage all students have access to at least one rural placement i.e., small community	Sue/All Sue Robin/Sue	Dec 2012 April 2013 Dec 2012
Evaluation form	Change it!!	Sue	ASAP!! Realistically Dec 2012
Other			
Unit managers frequently say "no" to students - need to target them with benefits of offering placement	Further discussion needed to assess feasibility/benefit	Sue	April 2013

Conclusion

The symposium was a rewarding and fruitful day of discussion, issue identification, idea generation, and networking, and was well received by the clinical community (see *Appendix 5*) as well as being providing invaluable input into the MPT clinical education program by the clinical community. The discussions have provided feedback and direction for the clinical education team. The team are extremely grateful to the clinical community for their ongoing support of the program and look forward to the next event in two years' time.

Slides from "Looking Back, Looking Presentation by Sue Murphy





Looking Back, Looking Forward

UBC Department of Physical Therapy
Clinical Education Symposium 2012

Increasing the capacity of Practice Education

- Need for additional clinical placements and preceptors
  - Overall
  - In specific clinical practice areas

What's New since the last symposium (2008)?

- Dr. Jayne Garland is Department Head
- Number of students increased to 80
  - 480 placements per year
- Multiple Mini Interview (MMI) format for admissions

New in Clinical Education:
- Northern and Rural Cohort
- Trial of APP Form as CPI option
- T-Res
- Automated Student Placement Matching

Increasing the capacity of Practice Education

- Marketing efforts
  - "New site" package / recruitment brochures
  - Brand / logo
  - Booths at the PABC AGM / CPA congress
- Health Authority Liaisons recruited:
  - Chiara Singh – FHA
  - Norm Hanson – IHA

Issues from the last symposium

Increasing the capacity of Practice Education

OUTCOME:
- Sufficient placements for a class of 80 students achieved – most of the time!

OUTSTANDING ISSUES/COMMENTS:
- More geriatric / rehab / neuro placements needed
- Placements are inequitably distributed between HA's / facilities
- ?More innovative models could be utilised

Partnerships / Communication between UBC and clinical practice

- Newsletter initiated
  - Current circulation of over 300
  - 3 issues / year
- Regular Column in *"Directions"*
- *Clinical Education Manual* revised and on website

Value-Added Clinical Placements

NEEDS IDENTIFIED:

- Alternate innovative practice education models
- More students to complete at least one rural placement
- More interprofessional education
- Clinical placements to be seen as beneficial for recruitment and retention
  - integrated with health human resource planning within Health Authorities

Partnerships / Communication between UBC and clinical practice

- Student expectations developed
  - Clarify performance expectations for each level of clinical placement
- PACE committee instigated
  - Meets twice per year
- Symposium follow-up report and second symposium

Value-Added Clinical Placements

- The student-led clinic at RCH was opened in June 2009
- Requirement that every student complete an "interprofessional" placement
  - Many rural placements are Interprofessional
- Students required to complete at least a third of their clinical placements outside the Lower Mainland
  - Also increases the likelihood of experiencing a rural placement

Partnerships / Communication between UBC and clinical practice

- Website revised
  - Limitations due to current platform
  - Watch for further improvements later this year
- ISSUE: How do we get people to view / use website???

Value-Added Clinical Placements

OUTSTANDING ISSUES / COMMENTS:

- Integration of clinical placement into human resource planning at the Health Authority level is difficult for the UBC Clinical Education Program to achieve – how can we help?

Support for Students

NEED IDENTIFIED:

- Support for students to facilitate desire for placements in non-Lower Mainland locations
  - Funds for travel
  - Contact with the UBC Department of PT during clinical placements

Support for students and preceptors

PRECEPTOR TASK FORCE: Thanks, Anne!

OUTCOMES FROM TASK FORCE:

- Continuing education would be a major source of recognition
  - Continuing education credits
  - Travel subsidies for workshops at UBC
  - Telehealth workshops
  - Financial credits towards workshops or texts

Support for Preceptors

- Training for preceptors
- Regular communication with UBC
- Involvement in practice education planning
- Preceptor recognition (from employers as well as academic institution)
  - Remuneration or continuing education credit

Support for students and preceptors

- Support for students / preceptors is an ongoing issue due to government reluctance to fund clinical education.
- Some suggested forms of recognition not currently feasible through UBC (e.g., credits toward courses)
- The issue of preceptor workload and burnout is difficult to address from the University perspective.
  - Additional sites may ease burden on individual sites / preceptors

Support for students and preceptors

- Ongoing Clinical Educator Workshops across province
  - 9 in 2009, 13 in 2010, 10 in 2011
  - > 100 participants per year
  - NCC will take responsibility for Northern / Rural workshops once hired
  - High levels of satisfaction from participants

Logistics

NEEDS IDENTIFIED:

- Timing of placements relative to other health professional programs (e.g., Rehabilitation Assistant)
- Requests for placements in general practice area rather than patient type
- Diversity of placements (rural/urban, practice areas, practice settings) important
- A common email address, regular reminder emails, a consistent yearly calendar and accessible information regarding issues such as liability coverage for students, would assist preceptors

Logistics

- Increased role for Clinical Placement Officer and Assistant
- Students complete placements in the following areas: Acute Care, Rehabilitation, Interprofessional (which includes pediatrics and rural), geriatrics or home care and out patients
- Common email address: pt.placements@ubc.ca
- Increased lead time instigated for calls for offer
- Increased use of HSPNet to facilitate more timely and effective communication

Private Practice

NEED IDENTIFIED: The reluctance of private practitioners to accept students due to perceived income loss

ACTION TAKEN:
- Specific Clinical Educator workshops targeted at private practitioners
- PP members on PACE and other committees / task groups
- PP perspective sought by Chiara and Norm in their work

OUTSTANDING ISSUES/COMMENTS:
- Number of PP placements improving
- When PPs "come on board" they generally stay
- Need for an effective way to reach PPs remains an issue

Logistics

OUTSTANDING ISSUES/COMMENTS:

- Increased lead time for calls for offer: met with mixed results
  - many sites cannot predict too far in the future what staffing levels will be
- When to send out calls for offer given the individual preferences of each site remains challenging!

Technology in Practice Education

Levering technology to provide support and training:
- to improve efficiency
- to overcome geographical barriers
- to overcome inability of preceptors to attend training due to lack of backfill.

ACTION TAKEN:
- Clinical Education workshops have been videoconferenced
- Facebook page initiated
- Preceptors directed to current web resources
  - "PEP" (preceptor education) program
  - "E-tips"

Evaluation of Practice Education

NEED IDENTIFIED: The *Clinical Performance Instrument* (CPI) too lengthy and cumbersome

ACTION TAKEN:
- Lengthy discussions regarding a new pan-Canadian evaluation form
- Megan is here!

OUTCOME:
- A new pan-Canadian form is being developed.
- APP being trialed as a possible interim alternative

Technology in Practice Education

OUTCOME:

- Video conferenced workshop generally successful although the ability for small group work and interaction was somewhat limited
- Facebook not successful – canned!

OUTSTANDING ISSUES/COMMENTS:

- Options for alternative format Clinical Educator Workshops (e.g., video connected or on-line) need to be explored

Administration of UBC MPT Practice Education

The contributions of the Clinical Education Officer and Clinical Education Assistant to the program have been outstanding and moving forward on many activities would be impossible without them.

Huge Kudos & Thanks to Carolyn and Ingrid for doing such a fabulous job!

Looking Forward

Future Directions – Where do we need to go and what do we still need to work on?

Help us chart our direction for the next 2-3 years!

Discussion from "Looking Back, Looking Forward"

Building Capacity:

- Need to change the evaluation tool (CPI). The unpopularity of the tool holds preceptors back from taking students. The need for a fillable e-form (rather than paper) was also highlighted
- Need to change culture – taking students is an expectation not a choice
- PTA programs are vying for offers - suggestion was made that PTA and PT students could team up and go out together
    - UBC needs to target non-PT unit managers and recruitment departments and "sell" student placements as a recruitment strategy (most hires are "through the grapevine")
- Private clinics could call patients in whose funding has run out to be treated by students
- Need to fill offers - smaller/rural hospitals offer and then no students come, which "turns preceptors off" and they do not want to offer again

How do we get more people to use the website?

- Add link on newsletter (also add link for Clinical Education Manual) - a click on a link is quicker than navigating the website
- Perhaps a session for Coordinators /Preceptors on the Clin Ed website on where to find what
- By making it fun, e.g.: 'UBC Challenge of the Month'— what are the objectives for a level 3 placement?

Interprofessional Placements:

- Provide a Definition of Interprofessional
- Home Health should be Interprofessional
- Paeds and smaller outlying areas also have team approach and are Interprofessional
- Have OT and PT go out on placement together
- Merge Interprofessional objectives with other area objectives

Northern and Rural Cohort:

- What defines 'rural'? Is Prince George considered rural? It is a major centre?
- Northern Cohort - support for students/logistics/accommodation/travel and marketing and matching

Preceptor/Clinic Recognition:

- Plaques for clinics – very well received
- Thank you email to preceptor directly after CPI comes back suggested

Other:

- Need to define geriatric – age? Treatment type? Acute/residential?
- New Grads working in private practice - speak to grads re: how they came into the program with a private mindset and now work in public. Ask them what caused the shift?
- HSPnet times out after 30 minutes – can we lengthen this?

Concurrent sessions

Communications and liaison with the clinical community: How are we doing?

Join a dialogue with ***Carolyn Andersson (Clinical Education Officer)*** about our communications. Our current communications strategy includes the website, "The Globe" newsletter, and a column in the PABC newsletter, as well as having information booths at events such as the PABC Education Day. We also offer workshops for clinical educators, the opportunity to volunteer on the "PACE" committee, and various other events such as this one. What do you need more information about regarding our various communication activities? What could or should we be doing differently? What do you like/not like about our current communications and how can we do better to get information out to you and to other clinical educators?

- Disconnect between preceptors and UBC; There exists a disconnect between UBC PT and Preceptor, perhaps site visits/lunch and update to preceptors?
- More personal contact, not just through HSPnet
- Email communications – fine to send emails but identifying the message is from UBC is great. Suggest that Clin Ed Team preface each email subject as "UBC PT:_____"
    - That way easily searchable and recognize something is from UBC
- Put appropriate web links in Clin Ed Team signatures (e.g.: Ingrid – HSPnet, Carolyn – Clin Ed Resource website section links)
- Like the newsletter, like X3/year. Suggest doing more highlights of PTs in community, to recognize people contributing
- Make our presence visible – maybe a hello and coffee or lunch would be appreciated – and put our faces out there
- Card mail out at Christmas appreciated, but more immediate thank you/appreciation would work better
    - E.g.: send out embedded email with graphics after preceptor has taken a student
- Also liked :
    - Plaques (they do put them up!)
    - Newsletter mentions
    - Small tokens of appreciation

HSPnet and student placements organization: Do you really know how it all works?

We get many questions about the "logistics" of placements such as: "If I have vacation days scheduled during the placement period---can a colleague of mine supervise the student? When will the student send his/her introduction letter? The student is asking for time off for various reasons (e.g., Concert, weddings, sick), is this allowed/acceptable?" Do you know the answers to these questions, and if not, do you know how to find the answers? Ingrid Dill (Clinical Placement Assistant) will answer your questions about HSPnet and the process of setting up a placement, including why certain procedures are followed and what constraints we are working within. Ingrid would also welcome input into what policies and procedures work well for you and which don't – in an ideal world, what would we change to make your life easier?

- Sites leave experience (clinical area) vague purposely – do not know which preceptor will be able to offer – too many changes
- Lack of familiarity with HSPnet
    - How/where to enter preceptor information and descriptions
    - Can't really enter description into offer since preceptors change last minute and no time to edit description
        - Description is for initial offer and last minute there is a preceptor/area change
- "physall" – vague, used on purpose
    - E.g.: if department has 'floaters?' – will not know area of practice ahead of time
- What do Clin Ed Team want to see in description in HSPnet – what would be beneficial specifically to students?
- Reply by date of 2.5 months = good
- Split placements – Three days public/Two days private, 50% geriatric/50% acute??
- Unit managers frequently say "no" – need to target them with benefits of offering placement

Student professionalism and readiness for placement and practice

With the larger class of students, we have seen a corresponding increase in the number of performance concerns from sites. Sometimes these concerns appear to be related to weakness in knowledge and clinical skills, and at other times professionalism appears to be the issue. What have you observed in your own area of practice or clinical sites around student preparation for practice or clinical placement? Are there areas that we need to specifically focus on in order to more effectively prepare students for placement, or areas where you feel the MPT curriculum needs to be strengthened? And are there areas where we do a great job? This is your opportunity to meet with Jayne Garland (Department Head) to discuss your ideas and brainstorm about creative future directions.

- Generational Issues with mobile devices – clear expectations need to be discussed
- Modeling of professionalism behaviours essential by preceptors/ professors – timeliness, time off, communication, formal use of language (profs/preceptors not always the best models!)
- Staff need to communicate about norming behaviours and expectations so students see consistency across staff
- Early identification and awareness of problems is key
- Reluctance to contact UBC could be removed if email (how are they going?) sent at week two
- Use of learning contracts could make expectations clear
- Self-assessment could be informative
- Supervisors may need to change expectations regarding readiness for placement
- Some students are overly competent in their competence!
- Role playing re: student unprofessional behaviours to bring home the message

Building capacity: Innovative models and new directions

Over the last three years we have had many offers from new clinical sites and new areas of practice. However we are still sometimes short of placements, especially in Neuro, Rehab, Geriatrics, and Private Practice. What can we do to build capacity (in these practice areas in particular) and what new types of placement could or should we be exploring? What do you need in order to be able to offer more – or different type – placements, and what can UBC do to facilitate this? Come and join Sue Murphy (Associate Head, Clinical Education) for a visioning think tank around future placement directions!

Ideas for building capacity in Neuro included:

- Utilising Paeds neuro settings (e.g.: CDC's/Sunnyhill)
    - There was some discussion that Paeds neuro is different than adult neuro but the majority felt that adequate neuro skills could be developed in either setting
- Medicine , geriatrics, Neuropsych - all have neuro components (track thro' T-Res)

Ideas for new areas of practice included:

- Ortho Trauma Clinic, BCCH
- Outreach ALS, GFS
- Mental Health, BCCH/UBC/Burnaby
- Student programs in PP
- Continence programs (some concern re: how much "hands on" students could do due to sensitivity of clinical area)
- Intensive Rehab OP programs at SMH/Lions Gate (Interprofessional with Neuro/Amps focus)

Other needs/ideas identified included:

- Dedicated CI for multiple students in clinical setting (? Funded by UBC)
- Focus on students following clients – continuum of care (acute - rehab – community etc.)
- Difficulty with juggling PT/PTA student at same time noted

World Café

My Supervisor is a Nurse!

"Interprofessional Learning" is becoming an increasingly important part of clinical education. It is likely that at times, PT students will be supervised by professions other than Physical Therapy. What are the advantages/disadvantages of this model and what guidelines (if any) should the Department put in place for these types of placements?

Discussion focused on the "pros and cons" of these types of experience, and the requirements to make these types of placements a success.

PROS	CONS
• Provides another perspective for student • Similar competencies btw disciplines • Another set of eyes • Enhances understanding of scope/shared scope • Understanding/exposure to the setting/environment, basics of another profession	• Differing disciplinary approaches to education and Philosophical approach to care • Assessment/differing approach • May miss out on PT basics • Differing professional cultures/boundaries

In order for these placements to be successful, the following needs were identified:

- Training/education of preceptors
- Attitude of profession, understanding of PT big picture
- Where in the program
- Independent learner – optimal in 3A, 3B
- Competent student/confident in PT
- Resources – PT visits by consult
- Well-functioning team
- Readily accessible
- Link to another PT school

Foundation skills – shared or PT-specific? > student expectations?

Purpose of placement/learning – professional issues, perspective, specific skills > if IP placement, then OK or, for one of six placements.

Concerns not in OP/IP neuro.

Specific learning objectives clear. If IP, then scope and understanding of learning objectives.

Understanding of their professional role, scope of practice, what the PT student can offer.

Home or Away: Out-of-Town placements

We currently require non-Northern and Rural Cohort students to complete two "out-of-town" placements (at their expense). Is this the right amount of out-of-town experience? Should we require that they do more – or less – placements out of the Lower Mainland? Or should we let students decide whether they want to go on an out-of-town experience or not and remove the out-of-town requirement?

Comments from Group 1

- Two placements seems right to most
- It broadens education
- Once there, it offers a new perspective
- One PT school in BC, but in a rural/OOT placement you treat anyone from anywhere
- Exposed to different populations and cultures
- The program is not teaching you to work in at one place – it's teaching you to become a well-rounded PT
- OOT placements are the expectation of many Allied Health programs, so it's comparable
- Cherry-picking placements would be uneven/unfair
- Each student has an equal 'burden'/cost for an OOT placement
- Competition for jobs in Lower Mainland is steep
- OOT = greater exposure, better chance for employment
- Need to get rid of 'elitist' attitude of being a 'big city PT'

Comments from Group 2

- There is value in being removed from your situation, however the 'receivers' need to come together to offer resources (e.g., accommodation)
- With other distractions gone it's easier to focus
- Helps with discharge planning for patients going back to a small community
- Smaller environment offers huge range
- Not focused on one type of treatment or unit – must problem-solve
- Breadth of experience
- Think outside the box – how do you know what you'll actually end up doing
- Students might be scared of lack of mentorship/resources/methods of education
- Can UBC help facilitate?

Comments from Group 3

- Two OOT placements is the perfect amount
- Students gain from the experience – they have to push the lines of learning
- Broader experience, especially OP
- Smaller locations have less resources to take from
- Rural is 'one stop shopping'
- Highlights different patients and their roles in life
- Managing safety and risk
- Expense is an issue
- Billeting?

Comments from Group 4

- Students "Should all go away!" They need to be exposed to organizational cultures – small vs. large
- Needs to be community involvement – they need to be shown the value of brining in a student
- Students need to remember to give back if they've been helped by that community
- Solicit costs support from communities
- Offer public discussion
- Bella Coola and Hazelton both have residences for visiting students
- Tap into the medical program system?
- Think of creative solutions for accommodation
- Rural is not a treatment – it's a place.

Technology Rules – or Does It?

Should technology-enhanced learning be used to replace time spent in the clinical setting? There is increasing interest in the educational world in "simulated learning", which includes such activities as working with standardized clients, virtual/online cases, working with hi-fidelity manikins, etc. Could one of the current six placements – or part of one of those placements - be replaced by another form of technology-enhanced learning experience? Why or why not? And if yes, what should that experience be?

Comments from Group 1

YES	NO
• Authenticity important in simulated learning • "Soft skills" (professionalism, ethics, teamwork) may work well or even better • Safe context to make mistakes • Technical and soft skill combination • Using 'live classroom' technology – oral or texting online • Ground rules – side questions to instructor – case presentations • Valuable distance learning – presentation followed by discussion • Good for learning about basic things • Process can be good • Use to supplement, not replace • Remediation an enhancement • Additional tools for preceptor for struggling students • Round table discussions – 20 virtual patients • Could increase PP involvement through p/t face-to-face and p/t TEL • Task-oriented, e.g., code blue, suctioning • Augment not equal to replacement • Good for prep • Can enhance learning, e.g.., PDA reference • Good for immediate feedback – increase self-awareness	• Decreased interaction with patients • Possible for some, not all • Cannot take away practical piece • No opportunity to actually touch • More appropriate for continuing education? • Adjunct only • Depends on type of placement – e.g., admin, research, business okay • Hands-on clinical cannot be replaced

Comments from Group 2

YES	NO
• If real-life simulator models could respond, could be used as good prep • Patient safety simulations e.g., falls, pulling out central line • Simulated risk management module/safety • Can simulate learning in any location • Technology to link preceptors • Would need professional development to allow optimal use of technology in the practice setting • SP good for stop/start learning • Patient partner programs good • Good for reinforcing skills pre-/post-licensure • Increased access to learning	• Does not help the emotional connection • Need as much hands on as possible • Different value on a placement • Precursor to clinical placement • Would lose "soft skills" learning/practice • Need the uncertainty and unpredictability and time pressure to fully practice • Not equal to leadership training • Complexity of human nature and healthcare not captured in technology

Comments from Group 3

YES	NO
• Great for orientation through online learning • VPs as introductory tool and to reinforce learning • Helps access to resources • Lots could be adjunct to clinical learning but not replace • Could target expertise and time of preceptor to focus on the face-to-face coaching and patient contact – use technology to through self-directed learning • Use clients as educators and standardized patients as a form of simulation • Probably more in academic context to decrease "deer in the headlights" of students and new graduates	• Not replace majority of clinical time

Split Placements - "Heaven or Hell?"

Sharing a student between two or more supervisors and clinical areas has advantages and disadvantages. It may increase capacity (some preceptors are more willing to take a student for part of the time than for a full placement) but is often more work to coordinate. What are some of the advantages and disadvantages of this model, should this be something the department is actively pursuing, and what "combos" of clinical areas might make the best partnerships?

- Overall, feedback for split placements was positive
- Facilities that are currently doing split placements and having positive results are:
  - Surrey Memorial (Acute/Community and Inpatient/Outpatient Neuro)
  - Nanaimo Regional (Acute/Community)
  - BCCH (has done 5 different clinics (one each day of the week) and rotate through this for five weeks
- In OT, they have been doing part-time placements for a while, including 4 days/week of clinic and of the 5th day, a student works on an independent project

PROS	CONS
• Student exposed to a continuum of care (if do part-time acute, part-time community) • Student exposed to a variety of settings • Potentially more placements (therapists are more willing to take a part-time student and many part-time therapists are currently not taking students because often only full-time therapists are permitted students) • Some community therapists are reluctant to take students because they have so much "documentation" to do (and this is down-time for the student), but if two community therapists could share a student or a student could be part-time community/part-time acute then this would provide the community therapist with independent time to do documentation when the student is not present and only try to schedule client visits when the student is present. • Sample "splits" are morning/afternoons and "blocked" days/week (i.e., M/T/W vs. T/TH). This is not possible for all clinic environments (e.g., MS Clinic only operates T/TH), but when a clinic is open all days/week then blocked days together are probably better. Do not do splits "horizontally" through the placement (e.g., first two weeks in one area and last three weeks in another area). • Potential areas for placements: o Acute (Inpatient →community) This would work for ortho, neuro, medicine o Ortho (prehab→acute→ OP) o Paeds (acute→community)	• Why do this when placements are already challenging for the student? • Need to select the correct students for this type of placement (student needs to be flexible, smart, doing well in the program, etc.) • Can be a very "disjointed" placement if not appropriate communication between the two supervisors • Facility needs to adequately support the two supervisors doing this type of placement because they may need to "meet up" on two occasions to complete the CPI and also have regular conversations throughout the placement to touch base on how the student is doing • Evaluation: time for the two therapists to communicate so only one CPI is completed. If there was an on-line CPI this would save a lot of time because then it could be emailed between the two therapists to complete. • Need to select areas that are compatible with each other (i.e., usually along the continuum of care or in related areas (examples: inpatient ortho→outpatient neuro, ortho prehab→inpatient ortho, potentially neuro clinic/neuro research (for an elective placement, but need to get the student feedback on this!). Cannot just link two areas that are not related in some way – this is too difficult for the student.

"I want to work in Private Practice!"

Of all the graduate licensed physical therapists in BC, approximately half work in a private setting. However our students currently complete a maximum of 33% - and sometimes none - of their placements in a private setting. Should we increase the number of mandatory private practice placements?

- Kelowna and Vancouver saturated
- Aging demographic > future in residential/hospitals/acute care, not 30s sports injuries
- Losing visibility in public sector, OP public clinics are closing
- It doesn't stop them from going into PP anyway

No

- Logistically not practical – not enough placements available
- Make optional, not mandatory
- Why should the public subsidize private practices?
- Government funded and other areas will suffer – students will not have skill set to work in public sector
- Not all private practice is manual therapy, e.g., Libby Swain, PT – neuro
- Students get interested in PT through sports injuries – have no clue about CR, geriatrics and other areas

Suggestions

- Think about the possibility of a student-run clinic in PP
    - Work with a corporate PT company such as Lifemark, CBI, PT Health
    - Value added to clinic
        - Back education class
        - Review article
        - Help with needs of clinic
        - Implementing best practice into clinic
- Three days public/Two days private?
    - Can students follow through? Evaluations?
- Students start in the public system when they graduate, then once they pass their practical exam they leave and go to work in private sector=using public for their short-term gains and then leave to private (how to prevent this?)
- Hire a clinical instructor to supervise students in PP
- Elongate placement weeks if it's a split placement
- Student to assist with marketing/admin in PP is okay
    - Educate PP clinics re: 80% practice, 20% admin

Work on:

- Mentoring preceptors in PP – tips on how to manage – special workshop?
- Market to public better, market other than sports – promoting alternatives to PP
- How to change students' mindset
- Market chronic disease management/aging population
    - Acute/residential will require more PTs in the future
- Department develops contract/agreement with WorkSafe BC and government institutions
    - 30% of contract to certain PP should support student 10%
- PP to change fee structure – call in all patients who have run out of benefits
    - Value-added – highlights the clinic
- Market as a UBC teaching facility
- Site visits – part of interview? To see different physio areas.

Areas of Practice

Students are currently required to complete one placement in each of the following areas: Acute Care, Rehab, Outpatient, Geriatric or Community, and Interprofessional (which includes Paediatrics), plus an elective of their choice if all other placements are successfully completed. Is this categorization of placements the optimal one? Does it provide a sufficient breadth/depth of clinical experience and is it easy for facilities/supervisors to classify their placement offers this way? Are there better ways to classify placement types?

Summary

1. IPE on its own is not workable
    - IPE goes across multiple areas
    - No clear definition

2. Acute Care category is too broad
    - Fear that students risk missing out on gaining experience in a particular skill set, e.g., CardioResp
3. Categories were too different
    - For example one is a setting (e.g., community) and another is a patient age group (e.g., geriatrics)

4. Need more than one acute care placement

5. Interprofessional practice should spread across multiple units rather than being a unit on its own

A matrix was proposed, to help ensure students have a broad experience. For example:

	Cardio	Neuro	???/Ortho
Acute Care1	50	30	20
Rehab	0	60	40
OP	50 (1A)	30	20
Community	10 (Geriatric???)	50	40
Acute Care2	30 (oncology/paeds)	30	30
Elective			

Evaluation Summary

Evaluations were received from 15 participants (63% response rate). The day was extremely well received by all who responded. Overall rankings ranged from 3 (one rating) to 5 out of 5, with over 60% of rankings at the 5/5 level.

100% of respondents felt that they had enough opportunity to provide input and suggestions, and that the interactive sessions were effective in enabling participants to provide input into the UBC MPT Clinical Education program.

Specific comments around the interactive sessions and about the provision of input included:

- Plenty of time to take part in interesting discussions
- I thought the discussions were great!
- Lots of time to talk and share
- I thought the small group format worked really well! It generated lots of discussion with others and ideas were built on and discussed
- Good mix of presentations and time for input of opportunities
- Good format breaking into small group discussions to present suggestions and debate the questions presented to us
- It (input) was encouraged and received well by faculty members

Suggested Topics for Future interactive sessions included:

- Models of supervision; more on assessment of student performance e.g., observational skills of preceptors; innovations in clin ed; emerging research in clin ed; rural placements; interprofessional placements and assessment of student performance; international trends in clin ed; community service, learning/community engagement.
- It might be nice to see who is offering what (perhaps a bit of peer pressure might be good :-) so people can see where the gaps are
- Are there areas of practice that should have greater emphasis with changing health care management, e.g., the role of the coach in management of chronic diseases

100% of respondents also reported feeling that they were updated in what was happening in Clinical Education in the MPT program. Comments included:

- Very encouraged by all that is happening in the department
- It was a very good update for me
- Energized!

Networking time was felt to be sufficient by 100% of respondents, although a couple of attendees said they would have liked more discussion time. The pace of the day was found to be “just right” by all but two of the respondents – the remaining two felt there was more to talk about and the day could (presumably) have been longer or allowed more discussion time.

Comments around networking included:

- Excellent opportunity for me to connect with colleagues on the Mainland. Well worth it!!
- The breaks were just the right length
- The lunch and coffee breaks really facilitated that (networking)

The venue and facilities were very well received. Comments included:

- Would have been nicer not to eat in a cafeteria style room as our room was so much nicer
- I thought they were REALLY great. The accommodations for me were just fine. I loved having the breaks in another room and being able to walk down the hall to the discussion sessions in the other Admin room worked well too. I enjoyed having the windows in the venue -- much better than windowless!
- The facilities were great… the food not so much
- Very nice venue
- Loved the venue
- Very nice; a bit difficult to find; I was wondering why the parking was not paid for by UBC
- Nice spot. Enough parking and food – that is all we need!

Overall the day was a great success. Summative comments included:

- Great teamwork -- I enjoyed all the presentations and feel much more informed now!
- It was nice to meet the team involved with coordinating the student placements. There was certainly a lot of positive energy and hard work put in to this.
- Thanks for including me.
- I think it may have been helpful to have a few more front line staff that actually have current experience with students to have that perspective as it struck me that there were not a lot of people there that are presently taking students.
- I appreciate that the timing was kept tight, which made it highly productive and exciting – no lingering to squeeze out the last possible comment from each session.
- Very well organized day. I appreciated updates on the new technology, especially T-Res. The world café was a very effective way to gain input from a number of people.
- Perhaps include some students in a portion of the day for them to present or reflect on some of what's working, what's not working.
- It was very nice to have input from a different perspective in having Megan present. She also provided very good background to the evaluation tool that she helped develop and currently under consideration to implement for UBC clinical placements.
- Excellent workshop. Great mix of presentations and time for interaction.

We look forward to hosting the next workshop in two years, which was the time frame over 75 % of participants requested!

Symposium Participant List

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