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Hogeschool van Arnhem en Nijmegen
HAN University of Applied Sciences

IOF-program 2012

Peer Assessment
Upper Extremity Complaints

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CONTENT

Introduction

This manual contains the IOF year program Peer Assessment 2012. The program focuses on Upper Extremity Complaints. KNGF Clinical practice guideline CANS (Complaints of Arm, Neck and Shoulder) and the Evidence Statement Subacromial complaints support the problem solving process of clinical problems presented in the program. The KNGF guideline Record Keeping supports assessment of patient records. These documents can be downloaded from https://www.kngfrichtlijnen.nl.
When you have completed the entire program, including pre-test and post-test questionnaire, you will receive 18 points for the KNGF quality register.

Peer assessment is a form of team learning, whereby participants provide each other of written feedback, oral feedback an scores. A peer is a person of equal status, in your case a member of your IOF.
Successful Peer Assessment processes depend on the safety of the learning environment and the competency of peer assessors. Participants should feel free to make mistakes and open to receiving feedback; peer assessors need to be well prepared and competent in giving improvement feedback. Rules for giving feedback are included in the manual.

This program is developed in cooperation with the Royal Dutch Society for Physical Therapy (KNGF), the HAN University of Applied Sciences, Institute Allied Health Studies and the Radboud University Medical Center, Institute Quality of Care,

The program designers encourage you to give feedback on the program. When you have any questions, please do not hesitate to contact us.

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Aims of the Peer Assessment Program

By participating in the program, you will develop the competencies *Physical Therapy Performance, Communication, Collaboration, Knowledge sharing and development* as defined by the KNGF.

The professional profile is online accessible:
http://www.fysionet.nl/ckr/beroepsprofielen/2014-01_kngf_beroepsprofiel-ft_20131230_1.pdf

The most important aims are:

- Improving evidence-based clinical reasoning, decision making and performance on the basis of clinical practice guidelines on upper extremity complaints.
- Improving professional communication by critical appraising patient records
- Knowledge sharing and knowledge development by and practice-based knowledge.

- Improving reflective practice by observing and critical appraising a peers' performance and comparing group views to personal views.

Program content and assessment

The effectiveness of the program is measured by three online questionnaires that will be administered at the beginning of the program (February 2012) and after completion of the program (June / July 2012).

1. Clinical reasoning in the context of four written clinical vignettes accompanied by a set of questions that can be scored on a 3-point scale.
2. Tree commitment to change statements (personal goals).
3. Self-Reflection Questionnaire; ten questions about your reflective practice.

Before the final assessment is administered, you will receive your personal goals as a reminder and you will receive a model answer to all the clinical cases that are presented during the program.
In September you will receive personal feedback on the results. When you have completed the program and all questionnaires, you will receive the accreditation points for the KNGF quality register. Table 1 shows the program schedule.

Table 1 Intervention Programs in both groups			Contact	Hours
	Period	Peer Assessment (PA)		
	Feb-2012	Online Test based on four clinical vignettes (TCV)	Online Independent	1,5
		Online questionnaire Commitment to Change Statements (CTCS)	Online Independent	0,2
		Online questionnaire Self Reflection and Insight Scale (SRIS)	Online Independent	0,3
	Feb-2012	Program manual Guidelines	By email	
Session 1	Feb-2012	PA of individual performance based on written clinical cases	Group session	3,0
Session 2	March-2012	PA of individual performance based on written clinical cases	Group session	3,0
	April-2012	Review personal record Review two peer records	Online Independent	0,5 1,0
Session 3		Debriefing of Peer Assessment results	Group session	2,0
Session 4	June-2012	PA of individual performance based on written clinical cases	Group session	3,0
	July-2012	Reminder of personal goals Answering key to clinical cases	By email	
	July-2012	TCV	Online Independent	1,5
		CTCS	Online Independent	0,2
		SRIS	Online Independent	0,3
	Sept-2012	Personal knowledge of results by email	By email	

Digital learning environment

HAN-SCHOLAR is the digital learning environment that offers you a library of relevant documents to the guidelines and a discussion board. You will obtain the instructions for enrolling on HAN-SCHOLAR.

Coaching

The Peer Assessment session will be coached by experts in the Peer Assessment method. Their names are:

- Henk van Enck
- Henk Nieuwenuijzen

- Volcmar Visser
- Marjo Maas

The coach supervises the Peer Assessment process and only gives feedback when necessary. The coach will not interfere in the process of giving and receiving feedback but will take care of an equal contribution of each participant and for a safe learning environment. After evaluation of the program, participants who are interested in performing the coach role, will be offered an additional training in order to continue the peer assessment process independently.

Feedback

Successful learning in Peer Assessment is also dependent on competencies of feedback receivers as well as feedback providers. Learning in teams is a shared responsibility. We provide you some rules for giving and receiving effective feedback.

Provide feedback

1. Make personal contact, empathize with the feedback receiver and tune in verbal and nonverbal signs of the feedback receiver.
2. Address observed behavior: “I saw that….”, “I hear you say that…”.
3. Provide feedback on a descriptive and not in a judgmental way.
4. Do not hesitate to be critical.
5. Be concise and concrete: “what went right, and what can be improved”.
6. Do not repeat feedback that has been given by others.

Receive feedback

1. Clarify what kind of feedback you wish to have in advance when you want feedback on specific performance areas.
2. Choose your assessors when you like.
3. Ask for clarification of feedback when necessary.
4. Ask for concrete improvement suggestions when necessary.
5. Reflect aloud on received feedback an summarize. Make notes when needed.

Peer Assessment Procedure for session 1,2 en 4.

Each sessions takes three hours. In session 1,2 and 4 the focus is on solving clinical problems. In each session you will perform in three roles:

a. The physical therapist (PT) role
b. The assessor role
c. The patient role

In the PT role you study the clinical case that is presented by the external coach. You solve the problem by reasoning aloud and you demonstrate diagnostic or treatment skills consistent with best available evidence. In the assessor role, you observe the performance of your peer and critical appraise this performance by using pre-defined performance criteria and provide your peer of concise verbal and written feedback. In appendix 1 and 2 you will find a feedback form for diagnostic performance and a feedback form for treatment performance.
In the patient role you simulate the patient problem using a brief role description.

There are three written cases available for each session, containing both assignments for diagnosis and treatment, allowing each participant to perform in three roles.
Peer assessment focusses on performance and allows for limited discussion time. It is important to maintain the time schedule as presented in table 2. However, when time is needed to clarify certain issues, a clinical case can be skipped.

Table 2 Peer Assessment Task Procedure

Time	Task	Therapist role	Patient role	Assessor role
5 min.	Study written clinical case and clinical assignment.	x	x	x
	Study simulation role information		x	
3-5 min.	Analyse problem by reasoning aloud. Explain your choice for intended examination or treatment.	x		
8-10 min.	Perform intended examination – or treatment task.	x		
3-5 min.	Fill out assessment form			x
4-5 min.	Provide oral and written improvement feedback.		x	x
	Comment on feedback and summarize	x		
25-30 min				

Peer Assessment Procedure for session 3

Between the second and the third session, you will be asked to submit an electronic patient record concerning a patient with shoulder complaints. Your record will be assessed by two of your peers and you will assess two patient records of you collegues. a scoring sheet containing quality indicators derived from the KNGF guidelines on record keeping and the audit framework used by insurance companies[1] (appendix 3). The procedures are as follows:

Before the third session

- Divide the CoP in subgroups of 3 participants.
- Create a WORD or PDF file of your patient record. Clearly explain to your patient for what purpose the electronic patient record will be used and make sure that you obtain an informed consent.
- Delete before uploading you patient record, all information that could trace the identity of your client.
- Upload your patient record following the instructions on the SCHOLAR-site and authorize you're the two collegues of you subgroup to assess them.
- You will find the scoring sheet, including scoring instruction on SCHOLAR.
  All assessment results should be submitted one week before the third session. Your coaches will collect the results and present them at the third session.

During the third session

- Study the feedback from your peers on your patient record

[1] http://www.healthcareauditing.nl/

- Discuss with you peer group the results. Try to find differences and similarities in the assessment results, using the indicators and criteria of the scoring sheet.
- Identify personal improvement areas and formulate goals.

Commitment to change

Before the fourth session you will receive by email as a reminder you commitments to change at the beginning of the program. You will be asked to indicate the extent to which your goals were achieved on a 3-point scale from 1 = not achieved, 2 = partly achieved, to 3 = achieved. Is usual that you learnt something you didn't plan in advance. Of so, please describe that at point 4 of the form. When you prefer to stay anonymous, please only use your KNGF-number.

Naam / KNGF-nr:

CoP-nr.

Date:

Commitments to change	Not achieved	Partly achieved	Achieved
1.			
Comments			
2.			
Comments			
3.			
Comments			
4. Spontaneous learning			

Appendix 1 Feedback form diagnosis

Instruction Please indicate how you rate the performance of your colleague on a scale from 1 (performance in this section needs to be improved on all performance indicators) to 5 (performance is satisfactory on all performance indicators). Please put <u>one</u> cross for each indicator (total 3). Be critical. Your colleague wants to know what is achieved and what could be improved.		1	2	3	4	5
Indicator 1 Analyze problem Plan examination	Has sufficient domain specific knowledge Demonstrates a clear reasoning strategy Formulates plausible conclusions Designs an appropriate physical examination plan tailored to patient needs and using the best available evidence (including measurement instruments).					
Indicator 2 Perform	Gives clear clinical examination instructions Approaches patient with respect Performs appropriate and technical correct clinical tests.					
Indicator 3 Evaluate	Evaluates and interprets examination results correctly. Designs an appropriate working diagnosis.					
Comments	Tips:					

Appendix 2 Feedback form treatment

Instruction Please indicate how you rate the performance of your colleague on a scale from 1 (performance in this section needs to be improved on all performance indicators) to 5 (performance is satisfactory on all performance indicators). Please put <u>one</u> cross for each indicator (total 3). Be critical. Your colleague wants to know what is achieved and what could be improved.		1	2	3	4	5
Indicator 1 Plan	Designs an appropriate treatment plan, tailored to (simulated) patient needs and using the best available evidence.					
Indicator 2 Perform	Gives an appropriate advise and clear instructions Performs appropriate and technical correct intervention skills.					
Indicator 3 *Evaluate*	Evaluates the preliminary results. Choses appropriate instruments to evaluate the results.					
Comments	Tips:					

Appendix 3 Feedback form Record Keeping

This feedback form is designed according to the updated KNGF guidelines on record keeping 2011 and the audit framework of health care insurance companies 2012.

0 = not relevant
1 = totally disagree / much improvement necessary
2 = disagree / improvement necessary
3 = agree / improvement possible
4 = Totally degree / no improvement needed

General indicators	**Criteria**	0	1	2	3	4
Completeness	There is sufficient information in the record available to make decisions transparent and plausible					
	The record contains sufficient information to communicate with other professionals (colleagues / referrals / clients / insurers).					
Transferability	The record is readable by both physiotherapists and other stakeholders in the health sector.					
Readability	The record is concise; the file does not contain redundant information.					
	Information is clear and unambiguous					
	Language is professional					
Consistency	The choices for diagnosis and treatment are connected to patient needs and logically connected to each other.					
Transparency	The record makes clinical reasoning and decision making transparant.					
Credibility	The record is credible / there is no reason to doubt the process or outcomes.					
Indicator 1	**Criteria screening and diagnosis**	0	1	2	3	4
Basic information	Reason for contact and care demand is clarified.					
	The nature, severity and possible localization of the problems are clearly described using the framework of the ICF.					
	Underlying medical / personal / external factors that affect the perceived problems clarified.					
	The course of the problems experienced so far is clearly described and the factors affecting it.					
	If relevant, the physical therapist asked permission from the patient to consult with the referring physician.					
	Red flags are screened.					
	The choice of a guideline / protocol is appropriate to patient problem.					

Aanvullend onderzoek						
	Choice for diagnostic tests is logically connected with the data from anamnesis.					
	The findings are clearly described, and where possible in size and number.					
Analysis and diagnosis						
	The physical therapy diagnosis is a summary and professional interpretation of the data collected in patient examination.					
	The course is described and the possible influence of personal and external factors is clear.					
	The prognosis is recorded and the possible influence of personal and external factors is clear.					
	Yes / No indication for physical therapy is clearly explained.					
Indicator 2	**Methodisch handelen bij vaststellen behandelplan**	0	1	2	3	4
Treatment plan						
	Treatment goals are SMART formulated and tailored to patient needs.					
	Interventions, including advice are clearly described.					
	Planned evaluation moments are recorded.					
Treatment						
	Patient information and advice is recorded.					
	Agreements with patient are recorded.					
	Changes in the course of symptoms are recorded.					
	Adjustments of diagnoses and/or treatment plan are recorded.					
Indicator 3	**Use of assessment tools**	0	1	2	3	4
	The choice for – and the use of assessment tools (patient reported outcome measures and performance measures) is relevant.					
Indicator 4	**Resultaat behandeling**	0	1	2	3	4
	Results are clearly described from patient perspective (PROM) and physical therapist perspective where possibile in size and numbers.					
	The report to the referring physician and / or other stakeholders is available.					