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 The Impact of Experiential Learning in a Pro Bono OT Clinic on Clinical Reasoning Development

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**ABSTRACT**

**Background:** Fieldwork educators have expressed concerns about the readiness of occupational therapy students for clinical reasoning in the practice setting. Experiential learning involving face-to-face personal interactions with clients facilitates the application of theoretical knowledge, and the development of professional skills, competence, and self-confidence. Having the opportunity for extensive hands-on time working with clients, such as is offered in a pro bono clinic structure, may positively impact student clinical reasoning development of occupational therapy students. **Purpose:** The purpose of this study was to explore the impact of participation in a student-run occupational therapy pro bono clinic on student perceptions of clinical reasoning ability. **Method:** The Self-Assessment of Clinical Reflection and Reasoning (SACRR) was administered in this quasi-experimental, one-group, pre-posttest study to a convenience sampling of 20 students enrolled in a 3-year occupational therapy doctorate program in the upper Midwest. **Results:** Results of a Wilcoxon signed-ranks test for nonparametric data indicated statistically significant improvements in SACRR results of 17 of the 26 questions with a statistical significance of p < 0.05. The students’ total score for the pretest and posttest (composite for all 26 items) also indicated statistically significant improvements after participation in the pro bono clinic. **Conclusion:** These findings add to the existing literature by describing the impact of specific experiential learning structures on clinical reasoning skill development. Comparisons are made to other health professions and implications for practice are explored. Further study of specific factors contributing to student clinical reasoning development within the learning structure of a pro bono clinic is recommended.

**Keywords:** experiential learning, occupational therapy, student-run clinic

**INTRODUCTION**

Clinical reasoning, also identified as professional reasoning, has been defined simply as “how therapists actually think when they are engaged in practice.”1 Clinical reasoning is a complex process that includes how practitioners plan, direct, perform and reflect on client care.1 Because clinical reasoning is an embodied process, it involves the therapists’ therapeutic use of self, including cognitive and intuitive processes, and unfolds differently depending on the context of the care delivered.2

Experiential learning involves hands-on experience in an actual practice environment with an emphasis on learner self-direction and reflection about the learning experience.3 Experiential learning has been identified as a powerful influence on clinical reasoning development as well as a vehicle for the application of theoretical knowledge, development of professional skills, competence, and self-confidence.3,4 However, the instructional methods associated with clinical reasoning development, such as debriefing, reflection, and performance-based corrective feedback have not been specifically investigated relative to their impact on clinical reasoning in the occupational therapy pro bono clinic setting.5, 6 The purpose of this paper is to describe the learning structure offered to occupational therapy students over a two-semester pro bono clinic and to quantitatively measure the impact on clinical reasoning development.

**Background and Need**

Development of student clinical reasoning skills is an expected outcome of the professional occupational therapy curriculum and is considered essential to success in practice.7 Several types of clinical reasoning have been identified, including scientific, diagnostic, procedural, narrative, pragmatic, ethical, interactive, and conditional reasoning.1 Because these different forms of reasoning are intertwined with one another in the therapy process, it has been proposed that the resulting therapy actions do not represent a parallel process but rather, the interaction between the student practitioner, the client, the therapy context, and the actual therapeutic activity.1,8 Experiential learning that provides the student with an opportunity to experience these interactions is recognized as essential to student development. For example, fieldwork educators in occupational therapy have expressed concerns about the readiness of students for use of clinical reasoning in the practice setting and support the value of hands-on-learning experiences, such as the opportunity to complete an assessment process and write client notes using electronic documentation formats used in most facilities.9

A number of instructional methods and resources have been identified as helpful to clinical reasoning development including the use of debriefing and performance-specific feedback using guided discovery and prompting questions. Evaluating final-Year OT students, students’ clinical reasoning skills were improved through corrective feedback if accompanied by suggestions for improvement.6 Modeling in the context of practice challenges coupled with opportunities for an individualized, performance-specific debriefing from fieldwork educators was helpful to student clinical reasoning development.5 Explaining the meaning of their actions was critical to student development as experienced therapists were more readily able to reflect-in-action; that is, to actively evaluate their thoughts, actions, and practices during treatment which is a skill not usually developed in students or novice therapists.2,10

Learning to recognize important cues and patterns has also been identified as essential to clinical reasoning development as novices learn to create links between data sources.1 Researchers found that the provision of a domain-specific protocol was helpful to novice therapists to help them more efficiently identify the problem and efficiently enact the steps of solving therapeutic problems.11 Similarly, engaging OT students in the use of theory is thought to strengthen the clinical reasoning abilities of students, help them connect the reasoning process with familiar language, and increase their likelihood of incorporating occupation into their future intervention.12,13,14,15

There are many forms of experiential learning which vie for time within the intensive learning structure of the occupational therapy curriculum. For example, simulation and standardized patient encounters, faculty-led experiences, student-run clinics, and interprofessional education are all considered valid forms of experiential education.7 The choice of the format of experiential learning offered is often dependent on the supporting research. The value of face-to-face hands-on experiential learning was first explored by researchers who examined the impact of participation in a one-week experiential learning program on the clinical reasoning skills of occupational therapy students.3 They found changes in both objective and subjective ratings of clinical thinking and clinical reasoning (p>0.05) in 25 participants, supporting the value of hands-on learning. Researchers recommended further investigation into the components of the experiential learning program that influence clinical reasoning, as well as the timing and amount of experiential learning needed. In a later study, higher dosing described as over 15 hours of time spent in supervised clinical activities had significantly more effect on self-perceived clinical reasoning skills versus a smaller dose of 3 hours.16

Much of the literature describing experiential learning within the pro bono clinic is descriptive in nature, representative of an interprofessional population, or not specifically directed toward the impact of learning on clinical reasoning. In a descriptive study, researchers found students, clients, and instructors value their participation in a pro bono clinic structure, but also indicated a need for further elaboration on a specific pedological structure to support students and clients in the pro bono clinic setting17. In a 2018 study, Willis et al18 engaged physical therapy students in two half days of clinic per week, coupled with a problem-based learning unit. They found that experiential learning, coupled with problem-based learning, had a positive effect on the clinical reasoning ability of physical therapy students in 6 areas of the Self-Assessment of Clinical Reflection and Reasoning (SACRR) scores regarding decision-making based on experience and evidence as well as self-reflection and reasoning. However, they also found that items dealing with uncertainty and the incorporation of theory into practice showed non-significant improvements. Seif et al19 measured the impact of participation in an interprofessional pro bono clinic on student clinical reasoning and interprofessional competence. The authors found that students from medicine, pharmacy, occupational and physical therapy, and physician assistant programs who participated as volunteers in a student-run pro bono clinic had a higher perception of clinical reasoning skills when compared to a control group (p = 0.002). Group differences were attributed to increased opportunities for hands-on learning. However, it was not clear whether the study results accurately reflected the profession of occupational therapy as the number of occupational therapy students who participated in the study was not reported. In addition, the learning structure of the pro bono clinic was not described.

Goldbach & Stella4 described the experiential learning course design of a 16-week occupational therapy pro bono clinic that utilized all of the primary components of a clinical setting. Through weekly student reflections, surveys, and exit interviews students reported the course as highly valuable to their readiness for level II fieldwork. Specifically, students reported positive student perceptions of fieldwork readiness as well as improved abilities in communication and documentation, confidence, and clinical decision-making. In regard to clinical decision-making, they reported greater comfort in thinking of new therapy ideas during the therapy session, planning ahead for sessions, being creative, interacting with clients, and having greater confidence in using a frame of reference to guide their treatment. Clinical reasoning ability was not quantitatively measured.

Given the lack of research specifically investigating the learning structures provided within the occupational therapy pro bono clinic and their impact on student clinical reasoning development, the purpose of this study is to describe the learning structure offered and to investigate the occupational therapy students’ perception of their clinical reasoning skills before and after participation in a two-semester experiential learning course involving student provision of occupational therapy service to clients within a pro bono clinic. This study builds on earlier quantitative and qualitative studies exploring the impact of experiential learning in short-term contexts and instructional processes impacting student clinical reasoning development.3,5,6,4,19

**METHODS**

***Ethical Statement***: This study was granted Institutional Review Board approval Reference #1096091720.

**Study Design**

This study was approved by the university’s Institutional Review Board, and informed consent was obtained from all students who participated in this study. This quasi-experimental, one-group, pre-posttest study used convenience sampling of 20 students enrolled in a 3-year occupational therapy doctorate program in the upper Midwest. Students were enrolled in a 2-semester practicum course as part of the doctoral curriculum. The student-run pro bono clinic was embedded into this class.

The participants included 20 female students. There were 18 students who identified as Caucasian, 1 of Asian descent, and 1 of Hispanic descent. Their ages ranged from 21-30 years of age. When asked if the participants had any experience working in a healthcare setting prior to participation in the pro bono clinic, 50% of the students reported 0-1 years of experience, 5 reported 1-3 years, 3 reported 3-5 years, and 2 participants reported over 5 years of experience.

**Materials and Subjects**

The pro bono clinic structure/materials included coursework designed to prepare students to treat 1-2 clients in the university pro bono clinic setting for approximately 6-8 weeks for two consecutive semesters in their second year of didactic coursework. Students worked in teams of four, with two fulfilling the role of “treating therapist” and two completing administrative tasks such as scheduling, room coordination and set-up, and aiding in therapy sessions.

The groups changed roles at the start of each semester. Therapy sessions were under the supervision of licensed occupational therapy faculty. Each student team completed a treatment plan (see Appendix A) and received feedback on their plan from their supervising faculty member before each session. Following the session with the client, student teams debriefed for approximately 15 minutes with a faculty member using a feedback rating form (see Appendix B). Student clinicians used an electronic medical record (EMR) to document evaluations, treatments, progress notes, and discharges. Feedback was provided on all documentation and final data entry was contingent on supervisor approval.

Study participants were provided information regarding the research study and signed an informed consent before participation. Participants were given a link to the Formsite survey with instructions to rank their self-reported clinical reasoning skills prior to the start of their participation in the pro bono clinic. Following the end of the second semester of the course, students were again asked to rank their self-reported clinical reasoning skills following their participation in the pro bono clinic and associated course.

The Self-Assessment of Clinical Reflection and Reasoning (SACRR) was administered via Formsite. The SACRR survey is composed of 26 questions reflecting on reasoning skills such as the application of theory to understand clients’ problems and proposed solutions, the ability to make judgments using clinical information, functioning in uncertainty, and intervention planning 20. The SACRR survey is a self-administered questionnaire that utilizes a Likert-scale to measure clinical reflection and reasoning (1-strongly disagree, 2-disagree, 3-undecided, 4-agree, 5-strongly agree). Spearman rank order correlation coefficient for test-rest reliability is r = 0.60 and Cronbach’s α (internal consistency) = .87 to .92 3. Author permission was not required.

**Technical Information**

The SACRR data was imported from Formsite and scored using Microsoft Excel. The pre and posttest scores were compared using the Wilcoxon signed-ranks test for nonparametric data using Microsoft Excel 16.0. The Wilcoxon signed-rank test finds a test statistic by first calculating the difference in the matched data. For example, responses to question 1 for the pretest and posttest were matched up by the student. Then, the difference (posttest response - pretest response) was calculated for each student, and the differences were ranked according to size. The ranks of the negative differences are summed, and the ranks of the positive differences are summed. The test statistic W is equal to the larger of these two sums. To complete our hypothesis test, the p-value of our test statistic was calculated. Finding the p-value depends on calculating the z-score of the test statistic using W, the mean, and the standard deviation from above. The z-score is found:

 

The z-score was then used to calculate the p-value in a standard normal distribution. Since this was a two-tailed hypothesis test, the p-value is found by calculating the area trapped in the tail by the z-score and multiplying it by two.

**RESULTS**

Results indicated statistically significant improvements in SACRR results of 17 of the 26 questions (Table 1) with a statistical significance of p < 0.05. The items showing statistically significant change were representative of theoretical reasoning (SACRR questions 7-10 and 26), self-reflection regarding decision-making (SACRR questions 1 and 23), problem identification and ability to plan interventions (SACRR questions 12,17,19 and 20), and ability to cope with uncertainty (SACRR questions 15 and 16. The student’s total score for the pretest and posttest (composite for all 26 items) also indicated statistically significant improvements after participation in the pro bono clinic.

**Table 1.** Changes in SACRR results



**DISCUSSION**

Significant differences were found in occupational therapy student perceptions of clinical reasoning skills resulting from participation in a two-semester pro bono clinic in the areas of theoretical reasoning, self-reflection regarding decision-making, problem-identification, ability to plan interventions, and ability to cope with uncertainty.

Significant differences found on SACRR items #

7-10 and #26 all pertain to theoretical reasoning, or the use of theory and frames of reference in practice. Items included: looking to theory for understanding a client’s problems and proposed solutions (7); looking to frames of reference for planning intervention strategy (8); using theory to understand treatment techniques (9); trying to understand clinical problems by using a variety of frames of reference (10); and using theory to understand intervention strategies (26). Students self-reported improvement in the use of theory may be due to the requirement that they provide a rationale as to the theory or frame of reference used in their treatment planning (see appendix A). The use of theory was also a component of their debriefing and feedback from their supervisor. Results showing dependence on theory use were consistent with typical characteristics of professional reasoning at the novice stage, as students generally depend on theory to guide practice as they do not have practice experience to guide them.1 Our study findings differed from those of Willis et al18 who found non-significant differences in the use of theory with PT students in a pro bono clinic. This may be explained by the longer length of time given to our clinic (two semesters instead of one) or by the explicit attention to theory in the course assignments. It is recognized that the non-explicit use of theory by practitioners is often not visible to students.15 This finding supports the value of explicit attention to the use of theory and multiple opportunities to apply theory in early experiential learning experiences.

Self-reflection about decision-making is represented in questions #1 (questioning how, what and why I do things in practice) and #23 (regarding a particular intervention with a particular client, determining whether it worked) of the SACRR and is commonly referred to as “reflection on action.”10 This type of reflection occurs after the fact and helps the student identify what worked and what did not and to consider alternative ideas.1 Improved abilities in reflecting on the conditions that support therapy success are also associated with improved skills in clinical reasoning.19

Royeen et al20 defined clinical reasoning in occupational therapy as “the reflective thought process that therapists undergo to integrate client evaluation information and to develop and implement intervention plans.” Improvements in students’ perceptions of their decision-making skills were surprising since the pro bono course did not include active use of self-reflection in the course structure. Willis et al18 suggested that the opportunity to learn across time positively impacted self-reflection. The debriefing sessions that were held after the conclusion of the treatment sessions and the feedback provided may have stimulated self-reflection as tailored supervision and guided questioning have been identified as helpful to clinical reasoning development 2. Further study is needed as to how much faculty prompting and debriefing is indicated, since faculty prompting related to clinical reasoning may also have a negative effect, depending on the amount of cognitive load perceived by students as well as their perceptions of self-efficacy.21

Similar to the findings of Goldbach & Stella,4 students identified improved skills regarding problem identification and the ability to plan interventions as represented in items #12, #17, #19, and #20 on the SACRR. Items included: asking “what if” when considering a variety of options for intervention strategies (12); regularly hypothesizing about the reasons for my client's problems (17); clearly identifying the clinical problems prior to planning intervention (19); and anticipating the sequence of events likely to result from planned interventions (20). In identifying and addressing problems, practitioners report using their own practice experiences to guide their actions 1. Since over 50% of students in this study reported having previous healthcare experience, it is possible that they did draw on their personal and practice experiences in problem formation and intervention. However, they were also able to supplement their lack of experience with input from experienced therapists. For example, in student intervention plans (see Appendix A) they identified problems and listed types of interventions following the format provided by the Occupational Therapy Practice Framework.22 In addition, students were required to identify support from the professional literature for each treatment activity with rationale, and supervising faculty provided feedback on their plans before implementation. Student perceptions regarding improvements in identifying and addressing problems suggest that the pro bono clinic structure was ultimately helpful to them in identifying important cues, recognizing patterns, and focusing their interventions on the most fruitful areas.1 However, it is possible that other structures, such as the availability of domain-specific protocols or direct modeling by expert therapists might be more efficient to help students identify and solve problems.11, 5 Since this clinic was extended over two semesters, higher dosing and extended time available for learning may have influenced study results.16 Further study is needed to identify the value of each distinctive component of the pro bono clinic structure to student clinical reasoning in comparison with alternative time dosing and learning structures.

Significant differences were found in two items of the SACRR #15 and #16 related to students’ perceptions of how they cope with change (15) and function with uncertainty (16). These items are reflective of student confidence in their practice skills and their ability to address unforeseen therapy challenges. Student perceptions of self-confidence are associated with increased skills in communication with clients and family members, improved ability to carry out planned therapy interventions, and to accurately document the results.4 Addressing unforeseen therapy challenges is associated with “reflection in action,” where practitioners think amid action and adapt to meet the demands of the situation.1 The ability to reflect in action is common in experienced therapists but not expected in student practitioners so this is a surprising finding.2 Confidence in coping with uncertainty was not found to be significantly different in physical therapy students who offered pro bono services over a one-semester course, so the significant findings in this study may be related to extended practice over two semesters or it may be specific to the occupational therapy profession.18 Findings may also be influenced by student opportunity to receive immediate corrective feedback and suggestions for corrective action after each therapy session.6 Future investigation in this area should include attention to both temporal and structural aspects of experiential learning in the pro bono clinic.

**Limitations**

There are several limitations to this study. Generalizability is limited by the lack of randomized sampling, the small sample size, and the lack of male representation. The SACRR scores were self-reported rather than objective measures of clinical reasoning. Finally, a more robust research design with a quantitative rating of the value of each element of course structure to student clinical reasoning development would have enhanced the value of this study.

Occupational therapy students who participated in a two-semester pro bono clinic reported increased abilities in reflection on decision-making, theoretical reasoning, problem identification, and intervention provision as well as the ability to cope with uncertainty. Pro bono clinic learning structures including therapy planning protocols and debriefing/feedback structures are discussed in view of the current literature. Explicit attention to supporting theoretical reasoning in pro bono clinic structures is warranted along with immediate feedback regarding communication, problem-solving, and use of therapy time. Further investigation into factors influencing student clinical reasoning development is recommended.

***Conflict of Interest Statement:*** We confirm that this work is original and has not been published elsewhere, nor is it currently under consideration for publication elsewhere. No Conflicts of Interest have been identified.

**References**

1. Professional reasoning in practice. In: Schell BB, ed. Willard and Spackman’s occupational therapy. 13th ed. Philadelphia: Wolters Kluwer,; 2019. p. 482-497.
2. Turpin M, Fitzgerald C, Copley J, Laracy S, Lewis B. Experiences of and support for the transition to practice of newly graduated occupational therapists undertaking a hospital graduate Program. *Aust Occup Ther J.* 2021;68(1):12-20. doi:10.1111/1440-1630.1269
3. Coker P. Effects of an experiential learning program on the clinical reasoning and critical thinking skills of occupational therapy students. *J Allied Health*. 2010;39(4):280-286.
4. Goldbach WP, Stella TC. Experiential learning to advance student readiness for level II fieldwork. *J Occup Ther Educ.* 2017;3(1). [doi.10.26681/jote.2017.010103](https://doi.org/10.26681/jote.2017.010103)
5. Copley JA, Rodger SA, Graham FP, Hannay VA. Facilitating student occupational therapists' mastery of occupation-centered approaches for working with children. *Can J Occup Ther*. 2011;78(1):37-44. doi:10.2182/cjot.2011.78.1.5
6. de Beer M, Mårtensson L. Feedback on students' clinical reasoning skills during fieldwork education. *Aust Occup Ther J*. 2015;62(4):255-264. doi:10.1111/1440-1630.12208
7. 2018 Accreditation Council for Occupational Therapy Education (ACOTE®) Standards and Interpretive Guide (effective July 31, 2020). *Am J Occup Ther.* 2018;72(Supplement\_2):7212410005p1-7212410005p83. doi:10.5014/ajot.2018.72S21
8. Toth-Cohen S. Using cultural-historical activity theory to study clinical reasoning in context. *Scand J Occup Ther.* 2008;15(2):82-94. doi:10.1080/11038120701534975
9. Hanson DJ. The Perspectives of Fieldwork Educators Regarding Level II Fieldwork Students. *Occup Ther Health Care*. 2011;25(2-3):164-177. doi:10.3109/07380577.2011.561420
10. Schon, DA. Educating the reflective practitioner towards a new design for teaching and learning in the professions. Jossey-Bass Inc, 1987
11. Kuipers K, Grice JW. The structure of novice and expert occupational therapists' clinical reasoning before and after exposure to a domain-specific protocol. *Aust Occup Ther J*. 2009;56(6):418-427. doi:10.1111/j.1440-1630.2009.00793.x
12. Bonsaksen,T, Grana KE, Celo, C, Ellingham B., Myraunet, I. A practice placement design facilitating occupational therapy students' learning*. J Mental Health Tra Educ Prac.* 2013 8(4), 169–10. Doi: 10.1108/JMHTEP-08-2012-0028
13. Ikiugu MN, Smallfield S. Instructing occupational therapy students in use of theory to guide practice. *J Occup Ther Healthcare*. 2015; 29(2),165-77. Doi: 10.3109/07380577.2015.1017787.
14. Leclair LL, Ripat JD, Wener PF, Cooper JE, Johnson LA, Davis EL, Campbell-Rempel MA. Advancing the use of theory in occupational therapy: a collaborative process. *Can J Occup Ther.* 2013 80(3),181-93. Doi: 10.1177/0008417413495182.
15. Towns E, Ashby S. The influence of practice educators on occupational therapy students' understanding of the practical applications of theoretical knowledge: a phenomenological study into student experiences of practice education. *Aust Occup Ther J.* 2014;61(5), 344-52. doi: 10.1111/1440-1630.12134.
16. Flowers M, Yates C, Fletcher J, Lowe, L. Does dosing of pediatric experiential learning impact the development of clinical reasoning, self-efficacy, and critical thinking in DPT students? J Allied Health. 2020; 49(3), 190-196.
17. Fröberg M, Leanderson, C, Fläckman, B, Hedman-Lagerlöf, E, Björklund K, Nilsson, G H, Stenfors, T. (2018). Experiences of a student-run clinic in primary care: a mixed-method study with students, patients and supervisors. *Scan J Prim Health Care* 2020; 36(1), 36-46. Doi: 10.1080/02813432.2018.1426143
18. Willis BW, Campbell AS, Sayers SP, Gibson K. Integrated clinical experience with concurrent problem-based learning is associated with increased clinical reasoning of physical therapy students in the United States*. J Educ Eval Health Prof.* 2018;15:30. doi: 10.3352/jeehp.2018.15.30. Epub 2018 Dec 25. PMID: 30586954; PMCID: PMC6354052.
19. Seif G, Coker-Bolt P, Kraft S, Gonsalves W, Simpson K, Johnson E. The development of clinical reasoning and interprofessional behaviors: service-learning at a student-run free clinic. *J Interprof Care*. 2014;28(6):559-564. doi:10.3109/13561820.2014.921899
20. Hickerson CPA. *Innovations in Occupational Therapy Education*, 2000. Bethesda, MD: American Occupational Therapy Association; 2000.
21. Klein M, Otto B, Fischer MR, Stark R. Fostering medical students' clinical reasoning by learning from errors in clinical case vignettes: effects and conditions of additional prompting procedures to foster self-explanations. *Adv Health Sci Educ Theory Pract*. 2019;24(2):331-351. doi:10.1007/s10459-018-09870-5
22. American Occupational Therapy Association. Occupational therapy practice framework: Domain and process (4th ed.). Am J Occup Ther 2020; 74(2), [doi:10.5014/ajot.2020.74S2001](https://doi.org/10.5014/ajot.2020.74S2001)

**Appendix A**

**Treatment Plan**

**OTH 872 Weekly Planning Document**

**Assignment:** Each clinic team will come up with a plan for the upcoming weekly client session.  All components below are expected to be addressed and shared with supervising faculty at a minimum of 24-hour advance. However, 2-3 days in advance will allow opportunity for feedback and correction prior to the session. Evidence supporting the treatment will be required as well as rationale.

**Pt. Name:**

**Diagnosis:**

**Precautions/Contraindications:**

 **Relevant details from occupational profile:**

**Model chosen to guide treatment and rationale:**

 **Frame of reference (if appropriate):**

 **List prioritized problem list here:**

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**Goal/Goals**

|  |  |
| --- | --- |
| **Interventions**  | **Time**  |
| **Preparatory Activities:**   |   |
| **Purposeful Activity:**   |   |
| **Occupation-Based:**   |   |
| **Education and Training:**   |   |

Evidence – identify resource(s) used in preparation for session (journal article, textbook page number, classroom powerpoints, etc).

Rationale (why these activities; refer to specific problems identified and occupational profile)

**Appendix B**

**Feedback form of Student Performance**

Student Name:

Date: Descriptors: Unacceptable = 0, Concerned - .5, Appropriate = 1

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Professional Skill Area**  | **0**  | **0.5**  | **1**  | **Comments**  | **Score**  |
| **Professionally dressed:** Student is wearing business casual clothing that allows them to perform their job duties.   |   |   |   |   |   |
| **Interpersonal Skill:** Appropriate use of therapeutic communication skills with peers and clients. Ability to apply variety of therapeutic modes to support therapeutic use of self.  |   |   |   |   |   |
| **Communication Skill:** Effectively communicates at a professional level. Student was able to speak in layman’s terms & check for client’s understanding before proceeding.  |   |   |   |   |   |
| **Effective session preparation:** Students are prepared for session by having materials ready for use and alternate activities available if needed. Able to grade activities up or down as needed.  |   |   |   |   |   |
| **Effective use of session time:** Sequence of session include warm-up, preparatory/purposeful and occupation-based activities that addresses targeted goals, summary and home application.  |   |   |   |   |   |
| **Use of constructive feedback:** Responds appropriately to constructive feedback from peers, clients, & faculty.   |   |   |   | .  |   |
| **Problem-solving:** Student demonstrated ability to problem solve issues that arose during the session (i.e. lack of space, equipment, time, distractions).  |   |   |   |   |   |
| **Professionalism & Responsibility:** Student was professional throughout session. Student was on time, took responsibility for his/her role related to client treatment.  |   |   |   |   |   |
| **Theoretical application:** Student was able to justify choice of intervention in view of client needs and theory/frame of reference.  |   |   |   |   |   |
| **Critical Thinking:** Student implemented an appropriate intervention that maintains the safety & integrity of the client. Intervention was appropriate for the client’s level, goals, setting, and research evidence.  |   |   |   |   |   |
| TOTAL SCORE/FEEDBACK  |      |