Setting Ourselves Up For Success: Strategies for Effective Clinical Learning Partnerships
Elaine Mormer, PhD
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While Waiting . . .

1. Complete Handout #1

2. Prepare your phone for audience participation:
   A. set it up so you can text a message to the number 22333 (message = ciddecs)
   OR
   B. go to the website: pollev.com/ciddecs.

Supervisors serve as the keepers of the faith and the mentors of the young. Theirs is a quiet profession that combines the discipline of science with the aesthetic creativity of art . . . It is a curious paradox that at their best they are least visible.
– Ann Alonso (1985)
(The Quiet Profession)

Acknowledgements

- Colleagues from other CSD programs
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- Colleague from University of Pittsburgh: Cheryl Messick & Catherine Palmer
- Colleagues from other professions: Mary Barnum & Sue Guyer
Austin Day 2013
Our Path Today

1. Background on clinical teaching
2. Multidisciplinary research on “effective clinical teaching” strategies
3. Input from students
4. Clinical Teaching tools to apply Evidence-Based principles
5. Audience participation

Assumptions and Ground Rules

- Everyone participating is intelligent, well-trained, cares about doing their best, and wants to improve
- Use civility and respectful communication
- Everyone’s voice is important and should be heard
- Everyone has expertise on this subject from which we can learn

Poll #1: What is your profession?

- Audiologist
- Speech-Language Pathologist
- Other

Poll #2: How many years of experience do you have as a CLINICAL INSTRUCTOR?

<table>
<thead>
<tr>
<th>Experience</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>One year or less</td>
<td></td>
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<tr>
<td>2-5 years</td>
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<td>6-10 years</td>
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<tr>
<td>11-19 years</td>
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<td>20 or more years</td>
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Communication Science and Disorders

Terminology... Clinical Education/Instructor

- Supervisor
- Clinical Instructor (CI)
- Clinical Educator
- Preceptor... Etc.

Students across all levels of clinical education...

SIG 11: Administration & Supervision Survey 2010 (Viktor, 2010)

- Survey from 406 respondents (94% SLPs) including university & practicing clinicians
- 67% indicated that having formal training on supervision is very important
- 53% indicated they would likely work to be "credentialed" as a supervisor if there was an option
- Education/training in clinical instruction is not currently "required" by ASHA or AAA (is required in other disciplines i.e., P.T; OT)

Knowledge & Skills (ASHA 2008)

- 11 Core Areas (handout 2) with 67 skills
- Developed for students, CFs, and employee supervision
- Parallels the Knowledge & Skills structure used to define standards for graduate education (CAA)

New in CAA Standards for 2017!

"Understand the role of clinical teaching and clinical modeling, as well as supervision of students and other support personnel"

Objectives of Clinical Teaching

- To affect change in clinician behavior that will in turn assess or modify client/patient function
- To encourage growth in students leading towards becoming independent clinicians
- To facilitate the student’s ability to successfully navigate the myriad of possibilities that clinical situations are sure to provide

Oratio, 1977; Walden 2011
Evidence Based Practice in Clinical Instruction Includes

- Best Available Evidence
- Clinical Expertise (CLINICIANS)
- Consumer Input (STUDENT)

Evidence from Varied Disciplines...

1. Medical
2. Nursing
3. Physical Therapy
4. Occupational Therapy
5. Social Work
6. Counseling
7. SLP & Audiology

What the Evidence Says is Important

- Optimizing Relationships
-Setting Expectations
- Providing Feedback
- Developing Critical Thinking Skills
- Questioning Techniques

Relationships...

Poll #3:
What is a relationship with someone who will impact your life significantly, is unbalanced in power, very close but not a blood relative, with someone you don't choose?

1. Your relationship with your pet
2. No relationship you ever want to have
3. The view of a student in the clinical instructor - student relationship
4. Your relationship with your mother-in-law

• An interpersonal relationship = an association between two or more people; it may range from fleeting to enduring
• Relationship triads in clinical education
  - Faculty Liaison – clinical instructor – student
  - Clinical instructor – student – client
  - Clinical instructor – client /family - student
• Instructor is in the Power Seat
  • More expertise/experience
  • “Grades” the student
  • Can influence future (jobs)
  • Network influence (with other colleagues)

Wagner & Hess, 1997 - SLP

Indeed. . .
• “The supervision relationship is probably the single most important factor for the effectiveness of supervision, more important than the supervisory methods used.”

Kilminster & Jolly, 2000 (med); Papastravrou et al., 2010 (nursing); Starkweather & Lamo, 2002 (nursing); Fugill, 2005 (dentist); Oneto et al., 1991 (SLP)

Interpersonal Communication
• When supervisees perceive positive regard & authentic support their clinical behaviors increase (Gillam, Roussos & Anderson, 1990; Shapiro & Anderson, 1989; Caracciolo, Rigrodsky & Morrision, 1988)
• First 5 minutes of meeting “sets the tone” (Farmer, 1985-1986)
• Students characterize “ideal” supervisors as those providing a climate of respect & consideration (Wagner & Hess, 1997)

Athletic Training CIs ranked Interpersonal Relationship as more important than instructional skills or clinical skills (Weidner & Henning, 2002)

UNDERMINES TRUST
• Criticism without nurturance
• Inconsistent behaviors
• Judgmental communication
• Inflexible & not open to suggestions

BUILDS TRUST
• Confidentiality
• Consistency
• Encourage & support risk-taking
• Honesty & sincerity
• Climate of mutual exchange

(McBride & Skau, 1995; Pickering, 1977; Costa & Garmston, 1989)
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Byrd, Hood & Youtsey, 1997 - nursing

Student and Preceptor Perceptions of Factors in a Successful Learning Partnership

Carol Y. Byrd, PhD, RN, CS*
Lucy Hood, MSN, RN
and Neila Youtsey, MN, RN

This study examines nurse preceptors and clinical teaching experiences, relating to both preceptors and the clinical learning experiences. The study of the perception of nurses' learning was altered significantly in the rating of their preceptors.

Literature Review

The use of perception in nursing education has modified educational outcomes. The role of the preceptor is critical in effective teaching experiences.

Results...

Factors hindering learning
- Lack of interest in teaching
- Autocratic & hierarchical relationships
  - (Lofmark & Wiklund, 2001; Myrick & Yonge, 2001)
- Feeling part of the team
- Positive regard & mutual respect
  - (Papastavrou et al, 2009; Aagard & Hauer, 2003, etc...)
- Stories cultivate learning and relationships
  - (Cernohous, 2006)

Factors promoting learning
- Feeling part of the team
- Positive regard & mutual respect
- Stories cultivate learning and relationships

Our students (N = 20) said...

In the clinical experience where you had the BEST Relationship with the Clinical Instructor, what did he/she do to foster...?

- Treated me with respect
- Allowed me to make my own mistakes
- Told me stories of his/her own clinic
- Tried to get to know me as a person
- Pushed me beyond my comfort in clinical activities
- Did not push me beyond my comfort in clinical activities
- Tried to be my friend
- Used questions to probe my thinking

The Supervisory Relationship Questionnaire (SRQ) (Handout #3; pg 5-7)
SAFE BASE SUBSCALE
1. My supervisor was respectful of my views/ideas
3. My supervisor used a collaborative approach
5. My supervisor was non-judgemental in supervision
6. My supervisor treated me with respect
7. My supervisor was open-minded in supervision
10. I felt able to discuss my concerns openly
11. Supervision felt like an exchange of ideas

COMMITMENT SUBSCALE
24. My supervisor was enthusiastic about supervising me
25. My supervisor appeared interested in supervising me
28. My supervisor appeared to like supervising
33. My supervisor appeared interested in my development as a professional

ROLE MODEL SUBSCALE
47. I respected my supervisor as a professional
52. I respected my supervisor as a clinician
53. My supervisor was respectful of clients

THE SUPERVISORY RELATIONSHIP QUESTIONNAIRE (SRQ) (see handout #3, pg 5)

Liberating Structure...
- Get into Groups of 4-6
- Task
  - Discuss and list 1-2 challenges you have run into, in establishing a productive relationship with a student
  - Identify specific possible strategies which could be used to improve the situation
  - Discuss in group and pick one to share with the audience

Some Group Challenges and Suggestions...

EXPECTATIONS...

EXPECTATION
- Definition
  - Anticipation of what will happen
  - Consideration of what is likely to happen
- Basis
  - Attitudes
  - Beliefs
Who has Expectations?

- CI's expectations of student
- Student's expectations of CI & placement
- CI expectations of CSD Dept
- CSD Department expectations of CIs & students

Polling question #4: Which best describes how you begin semester with a new student

- Give students hand-out of expectations
- Discuss expectations with students
- Expect the school gives student the information they should know
- Minimal communication prior to practicum activities beginning

Framework for Expectations

1. Workplace Culture
   - Subtle
   - Spoken vs. Unspoken
   - How are students viewed as equal members of the team; extra work; someone to do more work
   - Student interaction with support staff; communication mode (text; phone; email;)
   - FACEBOOK FRIENDS...

2. Logistics
   - Arrival, workspace, bathroom, lunch, dress code; parking ...
   - Cell phone use on site

   Example:
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Framework for Considering Expectations

- Student Background/experiences (what does CI know about the student?)
- Instructor Background/experiences (what does student know about CI?)
- Competency requirements in relation to patient population/setting
- Instructor mentoring style – Hierarchical vs horizontal
- Example: who talks to the parents of pediatric clients

3. Learning/Teaching Goals

Expectations vs. Perceived Experience

Expectation

Outcome

Negative Disconfirmation = DISSATISFACTION

Need for Expectation Management: The Evidence

OT Survey: Without specific expectations students exhibit initial difficulties acclimating to clinic environment (Foley, K. 2007)

Those who were provided with an organized orientation felt more belonging to the organization and adapted to their environment more quickly (Klein, H. & Weaver, N. 2000)

Goals → Changes in Behavior

- Student clinicians modify their behaviors when specific goals were developed & data was used to document achievement of targets
  - Beginning level student clinicians showed better improvement when goals were WRITTEN
  - Experienced student clinicians made progress with verbal goals defined in discussion
  - Fading of written plan possible with increased experience
**Tools**

- Typhon System
- Student electronic portfolios
- Clinical Instructor/Site Database
- Placement Expectation Worksheet

**Participation in Skills**

**Online Site Directory**

**Expectation Worksheet**

Handout #4
SQF Model:
(Barnum, Guyer, Levy & Graham, 2009)
The SQF Model of clinical teaching utilizes very specific Supervision, Questioning, and Feedback skills for the purpose of moving the student toward achieving clinical autonomy in both skill application and clinical reasoning.

Conscious Competency Model
(Howell & Fleischman, 1982)
The Conscious Competency Model distinguishes between levels of awareness and competence.

Conscious Incompetent
- "I don't think about what I know" (Unconsciously Competent)
- "I know what I don't know" (Consciously Incompetent)

Consciously Competent
- "I know what I know" (Consciously Competent)

Unconsciously Competent
- "I don't know what I don't know" (Unconsciously Competent)

The Learner in the SQF Model
("D" = developmental level)

D1
- Unconsciously Incompetent
- Consciously Incompetent

D2
- Consciously Competent

D3
- Unconsciously Competent

Breaking Down SQF: Supervision
Supervision is based on the situation

The Learner
The task
The Urgency and Consequences
(Levy et al., 2009)

Breaking Down SQF: Supervision
Situational Supervision Style
Situational supervision requires the preceptor to use a supervisory style that matches the needs of the learner in each given situation. (Levy et al., 2009)

S1
- Providing Direction and Coaching
- Stay close: "standing beside"

S2
- Being supportive and encouraging
- Create space: "over the shoulder"

S3
- Delegating
- Create distance: "over there"

Take a minute to consider how a student at each of these levels might behave? What traits might they exhibit? What would you expect of them?

D1
- Unconsciously Incompetent
- Consciously Incompetent

D2
- Consciously Competent

D3
- Unconsciously Competent
**Breaking Down SQF: Supervision**

- **Supervision Style 1 (S1)**
  - Coach and Direct

- **Supervision Style 2 (S2)**
  - Support

- **Supervision Style 3 (S3)**
  - Delegate

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**SQF**

A language we can use to understand a student's level of development as a clinician, and the type of supervision most appropriate...

Situation! Student development level and supervision level may vary across situations with the same student.

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Can you think of situation in which it would be appropriate to use each of these supervision styles within your practice setting?

- S1: Providing Direction and Coaching
  - Stay close: “standing beside”
  - Delegating

- S2: Being supportive and encouraging
  - Create space: “over the shoulder”

- S3: Delegating
  - Create distance: “over there”

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**One other situation factor...**

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**Bloom’s Taxonomy** (Bloom, 1956)

Classification of cognitive levels of understanding information

- Lower levels necessary before reaching higher levels

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*University of Pittsburgh Communication Science and Disorders*

Handout #6 p. 12&13
Bloom’s Taxonomy: Examples

Define terms: syntax; acoustic neuroma

Explain term in own words

Apply finding to possible diagnosis

Analyze test battery findings

Propose supplemental measures

Evaluate findings for court case

Understand

Define terms: syntax; acoustic neuroma

Remember

Evaluate findings for court case

Understand

Define terms: syntax; acoustic neuroma

Remember

Expectations for Learning: Setting Reasonable Goals

Target appropriate level

• D level...1,2,3?
• Bloom’s level...? Remember, create?
• Discuss Goals

Handout #7

Tool: SMART Goals

Specific: independently administer an oral sensory mechanism examination: otoscopy

Measurable: with minimal prompts from CI in 4 of 5 attempts

Achievable: will observe CI conducting exams; will develop a form & script to use

Relevant: done with many patients as part of initial evaluation, other tests depend outcome

Time-based: week 3 of practicum for 1st year student

SMART Goal Worksheet 3

SPECIFIC:

Correctly select/recommend customized hearing protection

ID appropriate diagnostic tools for use with patient, independently

Measurable:

Make correct recommendations for customized hearing protection =85% of the time

Develop dx plan with specific tool

Develop back-up plan for dx measures appropriate =85% of the time

Achievable:

Obtaining and reading information relevant to noise exposure and hearing protection options.

Observe CI conducting exams and will develop a form & script to use

Observe CI conducting exams; will develop a form & script to use

Relevant:

Skills necessary to successfully receive passing grade in this clinic

Development of individualized dx plan is necessary to establish management plan

Time-bound:

Within two months of time (dependent upon number of patients seen for hearing protection)

By 8th week of the term

LUNCH BREAK....maybe?

Learning Activity

• Think of a student you have or have recently had in clinic...
• Develop one learning goal appropriate for that student
• Compose goals by
  • Determining target level from Bloom’s taxonomy
  • Following SMART goals format (handout #7)
**When Disconfirmation is Minimal . . .**

- Better student – CI relationships
- Better learning outcomes through goals
- Decreased student stress
- Students feel part of the team
- Begin to develop confidence

**Reflection: Share with a partner**

- Look back at the challenge you described on the warm up worksheet

**Any way you might handle that challenge differently now?**

- Better understanding of student level?
- Communicating about expectations or grades?

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**Building Critical Thinking Skills: Questioning Techniques & Reflective Practices**

**Critical Thinking Skills are . . .**

- Purposeful, self-regulatory judgment which results in interpretation, analysis, evaluation and inference... (Facione, 1990)
- "the deliberate use of cognitive skills and strategies that increase the probability of a desirable outcome in a given situation." (Halpern, 1998)
- "critical thinking in a clinical area is clinical judgement" (Alfaro-LeFever, 1995)

**Socratic Approach**

Instructor poses thoughtful questions to probe areas of student thinking... calls on prior knowledge, assumptions, rationale

**Levels of cognition/development approach** questions aimed to stimulate specific levels of cognition as per Bloom’s Taxonomy/ SQF D level

**Describe the major strengths of this clinical education experience:**

"Let me work independently in areas I wanted to improve. I asked questions to promote learning."

"______ is always quizzing and asking questions! I felt like I learned something new every day."

"Saw a variety of patients, learned through ______'s questions, had a lot of independence but ______ was available when needed."

"A lot of questions that facilitate learning and promote critical thinking. Provided constructive criticism. Respects the student opinion. Very friendly and well organized which facilitates learning."
Training in Questioning Techniques (Malcolmson, 1990)

- Untrained nursing clinical instructors primarily used questions at lower levels of Bloom’s Taxonomy
- With training learned to use higher level questions resulting in increased frequency of higher level questions to students
- Outcome: students demonstrated higher cognitive levels of understanding

Poll #5: When you are doing clinical teaching, do you think of yourself first as a...

- Clinical Instructor
- Clinician
- No time to think about who I am
- Master Clinician

THE EVIDENCE: How CIs see Themselves

- Self perceived role of Athletic Training instructors resulted in different types of teaching strategies
- Different questioning techniques

(Barnum, 2005)

The primary role you function as?

**Clinical Educator**
- Used more student centered teaching strategies
- Encouraged student exploration & creativity
- Used more higher level questioning

**Service Provider**
- Used more instructor-centered teaching strategies
- Supported students’ ID and replication of skills & basic knowledge

(Barnum, 2005) – Athletic Training

Critical Thinking Skills & Self Confidence (Hoffman & Elwin, 2004)

- New graduates of nursing program who used higher level thinking skills were **less confident** in decision making
- New graduates who showed higher confidence in clinical decision making had **lower** scores in critical thinking
**Breaking Down SQF: Questioning**

(Barnum, et al., 2009 – Athletic Training)

**Level I: WHAT?**
- Elicit info from student on what they know (reinforce)
- Ask student to ID foundational knowledge
- “What are some causes of dysphagia?”

**Level II: SO WHAT?**
- Focus on mid-level cognitive processes
- Push student to analyze
- Student determines relevancy, applies concepts, sees contradictions...
- “How do these test results relate to our suspicion of an acoustic neuroma?”

**Level III: NOW WHAT?**
- Ask student for decision, opinion, solutions
- Target higher cognitive processes
- Elicit evaluation, analysis, & creation skills
- “What should we do next with this patient...why?”

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**Reflection**

- “the turning over of a subject in the mind and giving it serious consecutive consideration (Dewey, 1933)

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**Polling Question #6: Which form of reflection prompts are you most likely to use in clinic?**

- Ask them to define the strengths & areas to improve.
- Have them write reflective journals re: clinical experiences.
- Ask them to analyze their feelings/emotions, their process.
- I don’t have time for their reflections.

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**Video: Student Goal & Reflection**

(3 min; JM & CM Judging accuracy of productions)
**Questioning for Critical Thinking**

**Tools**
- Socratic questioning guide
- Level of cognition/development questioning examples
- Reflective Journal

**Classification of Questioning via Bloom’s Taxonomy**

**ACTIVITY – DEV QUESTIONS– Handouts 8-10 – see verbs on HANDOUT 9**

<table>
<thead>
<tr>
<th>Cognition Level</th>
<th>Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Remember</td>
<td></td>
<td>What is SLI? What is a perilymphatic fistula?</td>
</tr>
<tr>
<td>Low Understand</td>
<td></td>
<td>Why is it important to take a careful case history? Talk to me about how the patient’s hearing loss might impact our language measures.</td>
</tr>
<tr>
<td>Mid Apply</td>
<td></td>
<td>How would you counsel this lady in regards to her communication with her family?</td>
</tr>
<tr>
<td>Mid Analyze</td>
<td></td>
<td>What does the pattern of test results tell you about possible diagnoses?</td>
</tr>
<tr>
<td>High Evaluate</td>
<td></td>
<td>What do you consider the most important aspect of the treatment plan for this child?</td>
</tr>
<tr>
<td>High Create</td>
<td></td>
<td>Create a set of language goals for the IEP for this 7 year old with autism. Can you develop a novel method for measuring the patient’s communication skills in a community setting (e.g. restaurant)?</td>
</tr>
</tbody>
</table>

**Polling Question: I typically give daily feedback to my students via:**

- Written notes
- Verbal summary with specific strengths/weaknesses
- Verbal discussion about general aspects of the session
- Daily feedback not possible
FEEDBACK: Information provided to a student to reinforce, correct, or modify performance. Is less formal & often unstructured

EVALUATION: a more structured summary given to provide summative measure of performance

FEEDBACK VS. EVALUATION

Purpose of Feedback

- To reinforce strengths & foster improvements in the learner (Gorn 2001)
- “Feedback, when used correctly, provides the learner insight into actions and consequences, highlighting the dissonance between the intended result and the actual result” (Stallard 1977 in Menachery et al 2006)

Components of Feedback

- TIMING: immediate vs delayed
- SPECIFICITY: general vs. specific
- CONTENT: clinical skills, communication, clinical reasoning, professionalism
- FORM: Verbal, non-verbal, written; TONE
- PRIVACY: public vs private

SQF: TYPES OF FEEDBACK

- CONFIRM & REINFORCE: Nice job gathering a thorough case history
- CORRECTIVE to IMPROVE: Did you calibrate the tool before the session? Let’s double check those results to be sure we got valid responses
- GUIDING to MODIFY: Try moving your arm to the right to get a better view

EVIDENCE

- Behaviors perceived as “useful” by students:
  - Immediate verbal feedback results in higher performance ratings (Ho & Whitehill, 2009)
  - Balanced feedback with strengths & areas to improve
  - Specific feedback that includes details
  - Include rationale & evidence to support input
  - Focuses on student goals developed with the student

(Dowling & Witkopp, 1982; Nottingham & Henning, 2014a, 2014b)
Challenges in Giving Feedback

• When professional concerns occur, supervisors often give NO feedback (Hoffman et al., 2005)

• Difficult feedback is often indirect & not specific (Hoffman, Hill, Holmes & Proctor, 2005 – counseling)

• Positive & negative feedback can lead to growth/change. NO feedback doesn’t.

Avoiding negative feedback is NOT helpful!

Improve performance occurred when . . .

• Feedback is provided in a respectful manner

• Focuses on deficits important to the supervisee’s responsibilities

• Supervisors were trained to provide feedback in a manner that facilitated job performance

Supervisor Variables influencing change (Stallone, Teal & Boll, 2005)

Perceived Teaching Effectiveness

• “Effective clinical teachers” provide (Kelly, 2007)
  • Positive AND negative feedback
  • Timely feedback given in private
  • Receiving quality feedback was the strongest predictor of med students rating the teaching as “high quality” (Torre, Sebastian & Simpson, 2003)
  • Faculty who gave feedback more frequently received higher teacher ratings (Clay, Qae, Petrusa, Sebastian & Govert, 2007)

Training Supervisors to Give Feedback

• Training on methods of giving feedback can result in improved skills in providing constructive, timely, & balanced feedback in a respectful manner (Seaman, Krippendorf, & Bierman, 2005; Salerno et al., 2002)

• “High Feedback” associated with instructor being “learner centered” (Menachery et al. 2004)
  • Identified their own goals
  • Actively participated in own learning
  • Elicited feedback from others

I’m going to give you feedback now . . .

Instructors “believe” they give feedback more often than
• students perceive they receive
• data indicates they provide

(Marks et al., 2006; Lischeid et al., 2005) (medicine)
• **Sandwich** technique
  - First Positive Point
  - Something to Improve
  - Second Positive Point

• **Interactive** feedback: Ask learners to self-evaluate before giving feedback (Menachery et al. 2004; Holmboe et al., 2004)

**Summary: Effective Feedback**

- Is timely - immediate
- Begins with student self-evaluation
- Is balanced – includes ID of strengths & areas to improve
- Is specific & includes details
- Focuses on student goals developed with the student

**Feedback**

- One Minute Preceptor
- Encounter Card
- Self check

**THE ONE-MINUTE PRECEPTOR**

A Method for Efficient Evaluation and Feedback—strategy for quick, structured formative assessment

- Evidence for One Minute Preceptor
  - Preceptors (physicians) trained in OMP - greater self-confidence in rating students' abilities
  - Observers rated OMP encounters with students as more effective than traditional feedback (Aupard et al., 2004)
- Clinical Instructors trained on the OMP method improved in quantity and quality of feedback given to medical students (Salerno et al., 2003)

Feedback Cards (Handout #13 pg 21)
• Abbreviated Forms used to provide daily feedback
  • Student hands card to instructor requesting feedback
  • Clinical instructor completes card, first asking for student self-eval
  • Resulted in . . . .
    • Increased frequency of “feedback”
    • Immediate written feedback done efficiently
    • Increased satisfaction with teaching received

Rate Your Feedback Skills (Handout #14 pg 22)
• Feedback Self-Evaluation Checklist
  • A self-reflection tool to examine YOUR use of feedback techniques

Poll: 15% solution....

FOLLOW UP ACTIVITY
• In the next week complete the Clinical Instructor Self-Evaluation Form (Handout #15, p. 23)
  • ID 1-2 target goals for yourself to enhance your clinical teaching practices