The Clinical Skills Assessment Handbook describes how student clinical skills assessment practices are standardized in the Masters of Physical Therapy Program.
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The following abbreviations are used throughout this document:

**S5**: Step 5 represents the formative, competency based assessment of clinical skills which follows the Step 4 in the Student learning strategy teaching method.

**CSA**: Clinical Skills Assessment represents the formative, competency based assessment of clinical skills which follows the review lab in the traditional teaching method.

**S6**: Step 6 represents the summative and integrative assessment of clinical skills which occurs at the end of an academic block of teaching based on skills taught in both the Student Learning Strategy and the traditional method of teaching.

**OSCE**: Objective, Structured Clinical Examination is the type of assessment method used in the S6. The assessment uses a standardized question, a standardized checklist, standardized patient and the same examine.

**SLS**: Student Learning Strategy is a method of teaching students clinical skills in a step-wise progression involving peer instruction. There are six steps in the SLS, each having specific goals within the steps, and are represented by: S1, S2, S3, S4, S5 and S6.

For more information, refer to the [Learning Clinical Skills](#) document.
Understanding the Level of Learning with Clinical Skills

Learning physiotherapy clinical skills (competencies) is one of the main components of the MPT program. The MPT curriculum is designed to teach clinical skills from the National Curriculum Guidelines 2019 (Canadian Council of Physiotherapy University Programs (CCPUP), 2019) under the direction of the Competency Profile for Physiotherapists in Canada (National Physiotherapy Advisory Group (NPAG), 2017). The NPAG Competency Profile describes a level of learning clinical skills that are, “basic and represent the minimum level expected at entry-to-practice”, (NPAG, 2017).

Since 2012, program evaluation activities have informed the MPT program about the effectiveness of these teaching strategies. Marking practices of faculty coaches were reviewed and the results indicated that there were no statistically significant inter-faculty coach marking variations. However, student perceptions of differences between faculty coaches and how they assign marks continue to persist (Clinical Skills Assessment Working Group Report, 2018). As there are 18-CSAs/S5s in MPT1 and 5-CSA/S5s in MPT2, a perceived inequity of marking may contribute to student stress.

In 2017-18, all faculty coaches were oriented to new CSA/S5 guidelines. The guidelines were intended to promote a more systematic approach to marking clinical skills. In addition to these guidelines, Faculty Coaches spent time debriefing post-assessment. Approaches to marking were discussed, and in some cases checklist items were weighted. Relying on a weighted checklist proved frustrating to some faculty as students could perform all the skills on a checklist, but the student’s overall performance could be seen as unsatisfactory. In other words, checklists could not tell the entire story about student performance, and faculty coach expert judgements were restricted if the checklist was the only consideration when assessing student performance. Also if half of the 23 assessments included debrief session, 11.5 hours of 5 faculty coaches time would be spent on this activity (Clinical Skills Assessment Working Group, 2018).

It was also apparent that faculty coaches had different expectations regarding student performance when assessing students. Anecdotal feedback from students includes:

“A faculty coach told students that he/she never gives 20/20 (inferring that no student will be good enough to receive an “excellent” rating).”
“A faculty coach told students that their performance was so good that the students could teach the class (inferring that the student was an expert after 2 weeks of learning a clinical skill, which of course is incorrect).”

These comments reflect a critical theme in the MPT program: students perceived that faculty coaches do not mark in a unified marking approach, and there is a disparity in faculty coach expectations for student skill levels. There is also an inordinate amount of faculty coach time spent discussing and deliberating weighting of checklist items. To address these issues, the Clinical Skills Assessment Working Group recommends the adoption of:

A. **A model of skills acquisition** to ensure both students and teachers have a common expectation of clinical skills performance, and

B. **A competency-based, formative assessment method** for clinical skills that promotes effective and fair rating of student performance.

**MPT Program: A Model of Clinical Skills Acquisition and Beyond**

As of 2017, a literature search of models of skills acquisition utilized in physiotherapy education found no information on this topic, however the nursing and medicine education literature describe two models of skills acquisition which help guide educators when teaching clinical skills.

**Dreyfus and Dreyfus’ model of skill acquisition:** Dreyfus and Dreyfus’ work was initially applied to skills acquisition in math, chess and pilot training (Dreyfus & Dreyfus, 1980).

“Dreyfus and Dreyfus hypothesized that a detailed understanding of the stages through which skillful performance develops is essential to program design and the facilitation of the acquisition of high-order skills. One advantage of such a level-based approach is that it allows instruction to be formulated and targeted to the learners’ ability. A novice learner needs practice with and repetition of the rules for the particular skill, whereas the expert needs encouragement and opportunity to explore novel applications of the skill”

(Williams & Williams, 2017)

**Pertaining to the MPT Program:** Whether instructors teach clinical skills using the peer-assisted learning or traditional methods, initial skills instruction is context free. To acquire a skill, students follow a “checklist” in their minds; they are not applying the skill with any clinical context or experience.
The Dreyfus model, initially broke down the process of practical skill acquisition into five distinct stages however this model was adapted to include a sixth: *novice, advanced beginner, competent, proficient, expert, and master* (Williams, Byrne, Williams, Williams, 2017, p. 51):

- **Novice**: context free, non-situational, learner uses rules to determine action. Improvement through self-observation, instructional feedback;
- **Competence**: only after considerable exposure to real situations;
- **Proficient**: increased practice exposes the performer to a wide variety of typical situations. Student thinking is more holistic and analytical, still relying on rules, guidelines;
- **Expert**: performer relies on intuitive experience to determine action;
- **Master**: only takes place when the expert does not pay attention to their own; and performance but uses all mental energy to the action (Dreyfus and Dreyfus, 1980).

**Benner’s model of skill acquisition**: Benner’s focused on nursing education in her book *From Novice to Expert* (Benner, 1984) and proposed a model in which students pass through five levels of proficiency while acquiring and developing skills:

- Novice/beginner,
- Advanced beginner,
- Competent,
- Proficient, and
- Expert.

The different levels of learning reflect a student’s change in, in understanding and learning skills. Students at first rely on abstract principles and move to apply them as concrete experiences. Students progress to view a clinical situation where there are many aspects to consider, to seeing the clinical situation in a more “holistic view” and acknowledging the relevant factors. The remaining progression is for students to observing within the clinical situation to performing these skills actively (Altmann, 2007). In other words, “(a) move from novice to expert is characterized by the transition from explicit rule-governed behavior to intuitive, contextually determinate behavior. Progression from novice to expert is not guaranteed; not every nurse becomes an expert” (p. 115).

In summary, Benner’s and Dreyfus’s work proposed alternative ways of learning to the more traditional thinking about learning clinical practice skills. Benner believed that skilled pattern recognition can be
taught and will lead to advancement through the stages. Both the Dreyfus & Dreyfus and Benner’s models of skills acquisition emphasize that teachers must consider the context of the learning for the student when making judgements regarding a student’s satisfactory or unsatisfactory performance (Dreyfus & Dreyfus, 1980; Benner, 1984). No matter what the advancement of learning, the student requires immediate feedback about the accuracy of clinical skills and judgments.

**A model of skills acquisition in the Master of Physical Therapy Program:** In relation to the MPT program, the previously described models highlight the importance of the faculty instructor recognizing that the student can only learn basic skills within the academic portion of the program. The student will learn from experience in their clinical education more information that helps the student recognize similar and dissimilar clinical scenarios. Adopting a model of skills acquisition for the Masters of Physical Therapy program has the advantage of clarifying student and faculty expectations regarding clinical skills performance thereby addressing concerns raised by students and faculty coaches regarding ambiguity of level of performance necessary for student progression.

The Department of Physical Therapy adopted a *Model of Skills Acquisition and Beyond* (Curriculum Committee, 2018) to better define expectations for both students and instructors. Borrowing from models of learning (Benner, 1984; Dreyfus & Dreyfus, 1980) the MPT *Model of Skills Acquisition and Beyond* suggests that student knowledge and skills are built in a step-wise and planned manner. Furthermore, the model describes the expected clinical skills level of a student given certain landmark times in the MPT program.

**Table 1. Model of Skills Acquisition and Beyond**

<table>
<thead>
<tr>
<th>Level of Learning</th>
<th>MODEL OF SKILLS ACQUISITION AND BEYOND</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Point in Time</strong></td>
</tr>
<tr>
<td><strong>Novice</strong></td>
<td><em>During academic courses:</em> All assessments of clinical skills or competencies are informal, formative assessments.</td>
</tr>
<tr>
<td></td>
<td><em>At the end of a body system:</em> All assessments are in the form of an objective clinical structure evaluation (OSCE) which are more formal, summative assessments.</td>
</tr>
<tr>
<td></td>
<td>Both the assessments during the academic courses and at the end of a body system fall under the Novice description of Dreyfus’ model: The learning is context free and largely non-situational. The learner uses rules to determine action; improvement occurs through self-observation, instructional feedback (Dreyfus &amp; Dreyfus, 1980).</td>
</tr>
<tr>
<td>Level of Learning</td>
<td>Point in Time</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Advanced Beginner</strong></td>
<td><em>Beginning of clinical placement:</em> The ACP tool suggests that at this point in time, “the student requires clinical supervision 75% to 90% of the time managing patients with simple conditions and 100% of the time managing patients with complex conditions. The student demonstrates consistency in developing proficiency with simple tasks (e.g. chart review, goniometry, muscle testing and simple interventions). The student initiates, but is inconsistent with comprehensive assessments, interventions, and clinical reasoning. The student will begin to share a caseload with the clinical instructor” (Mori <em>et al</em>, 2015). Refer to the Canadian Physiotherapy Assessment of Clinical Performance (ACP) 2015 for further descriptions of rating scale/anchors.</td>
</tr>
<tr>
<td><strong>Competent</strong></td>
<td><em>At the end of clinical placement:</em> Refer to the ACP 2015 descriptions of rating scale/anchor descriptions. Students are expected to achieve near the “Entry-level” assessment rating by the end of the MPT program. Students are considered competent only after considerable exposure to real situations (Dreyfus &amp; Dreyfus, 1980).</td>
</tr>
<tr>
<td><strong>Proficient</strong></td>
<td>1-2 years out in clinical practice. The graduate physiotherapist is exposed to a wide variety of typical whole situations. The physiotherapist uses a more holistic and analytical approach; however, they still rely on rules and guidelines.</td>
</tr>
<tr>
<td><strong>Expert</strong></td>
<td>3-5 years out in clinical practice. The physiotherapist relies on intuitive experience to determine action (modified (Dreyfus &amp; Dreyfus, 1980)).</td>
</tr>
<tr>
<td><strong>Master</strong></td>
<td>&gt;5 -10 years out in clinical practice. Only takes place when the expert does not pay attention to his own performance but uses all mental energy to the action (Dreyfus &amp; Dreyfus, 1980).</td>
</tr>
</tbody>
</table>
Teaching Clinical Skills in the Master of Physical Therapy (MPT) Program

The MPT program teaches clinical skills primarily through two main evidence-informed teaching methods: peer-assisted learning, and a traditional instructor-led learning.

The peer-assisted learning method (Williams & Reddy, 2016) of teaching clinical skills provides all students with an opportunity to teach and practice core clinical skills, to develop a novice level of learning and be evaluated reliably on relevant skills. Peer-assisted learning occurs in the program’s Student Learning Strategy (SLS), which involves students learning through five steps: Step 1 involves independent learning; Step 2 involves a faculty instructor teaching peer instructors; Step 3 involves a peer instructor teaching students; and, Step 4 involves students discussing their learning needs and practicing skills with a faculty coach. Note: Not all clinical skills are taught using the SLS. Certain clinical skills require faculty supervision due to safety concerns while other skills lend themselves to be taught directly by an instructor, or there is inadequate equipment.

There are 6 distinct groups of people responsible for this teaching or learning clinical skills: course coordinator, faculty instructors, faculty coaches, peer instructor, student learners and Student Learning Strategy (SLS) groups.

**Step 1 (S1):** Independent preparation involves pre-reading notes/text/pre-view video as identified on the lab notes on UM Learn. A pre-lecture or lab quiz may precede the actual classroom experience. The quiz is found on UM Learn, and may consist of a few multiple choice questions, 1 or 2 very short answers (a phrase or fill in the blank). The quiz will be available 1 week ahead of time.

**Step 2 (S2):** The faculty instructor will demonstrate and teach specific skills to peer instructors using the lab outline. Peer instructors are expected to practice the skills they would be teaching during this time period. Instructor provides feedback and correction to the peer instructors. Independent review/practice prior to the S3 may be required.

**Step 3 (S3):** No faculty coaches are present. All students have completed S1. Each peer instructor teaches the clinical skills to 4 students. Each student will practice the specific skill on another student and provide each other with constructive feedback. At the end of the S3 session, the student group
ranks the clinical skills from hardest to easiest on the clinical skills, including any questions for the Faculty Coach (FC) on the Clinical Skills Confidence Form (see below). The student group brings the confidence form to the FC for the S4 lab.

**Step 4 (S4):** This learning session atmosphere is relaxed and somewhat informal as the session is intended for students to refine their skills, and is, driven by student’s self-assessment (Step 3). Faculty coaches will use their judgement regarding which skills to review with the group, however students are encouraged to ask questions and request a review of particular skills as needed. Students will demonstrate on each other and the faculty will provide interactive coaching while observing student performance of skills. Questions/demonstrations will guide the skills reviewed.

The *traditional faculty-led learning* method consists of an instructor teaching all students particular skills. The traditional method of teaching clinical skills usually involves teaching the class in a split groups (half the class) at a time. All of these types of labs may be followed with a *Review lab* in which students discuss their learning needs and practice skills with a faculty coach, which is identical to the Step 4 process. The following are examples of clinical skills taught using the traditional method, recognizing that this list is not exhaustive:

- graded exercise testing
- cervical spine stability testing
- biomechanical exam of the spine
- counselling and Interview skills
- group education
- reflective practice
- transfers and gait re-education

Other methods of teaching clinical skills in the MPT program include sessions using standardized patients, model patients, experiential learning, role playing, and simulation.

The following two tables represent an overview of the two methods of learning clinical skills, the *peer-assisted* method (shaded) and the *traditional* method.
Table 2. MPT Learning Skills Activities

**LEARNING CLINICAL SKILLS ACTIVITIES**

**Expectations of students:** Students actively participate in the labs. Additional independent study time is expected for all students participating in these learning sessions. The degree of independent study will vary from student to student.

<table>
<thead>
<tr>
<th>(S= step)</th>
<th>Who</th>
<th>Time</th>
<th>Expected Learning Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1</td>
<td>All students</td>
<td>Independent reading</td>
<td>Prepared to effectively participate in teaching session S2 and S3 labs</td>
</tr>
<tr>
<td>S2</td>
<td>FI + 10 PI /- FC</td>
<td>2 hours</td>
<td>PI has practiced skills taught to the degree required to teach peers in S3</td>
</tr>
<tr>
<td>S3</td>
<td>PI + 4 student learners</td>
<td>Usually 2 hours</td>
<td>Student learners practice clinical skills specific to the lab. Student learners self-assess their confidence level with the new clinical skills. SLS groups complete the Clinical Skills Confidence Form and include specific questions.</td>
</tr>
<tr>
<td>Traditional Lab</td>
<td>FI and ½ or all class +/- FC</td>
<td>As above.</td>
<td>As above.</td>
</tr>
<tr>
<td>S4</td>
<td>FC and SLS group</td>
<td>1-2 hour scheduled into timetable</td>
<td>Student learners focus and practice skills identified on the Clinical Skills Confidence form. All student learners are responsible for improving skills prior to the assessment of clinical skills in S5.</td>
</tr>
<tr>
<td>Review Lab</td>
<td>FI +/- FC and ½ or entire class</td>
<td>As above</td>
<td>As above.</td>
</tr>
</tbody>
</table>

**CLINICAL SKILLS FORMATIVE ASSESSMENT ACTIVITY**

**Expectations of students:** Students perform a selection of clinical skills at a novice level.

<table>
<thead>
<tr>
<th>Type</th>
<th>Who</th>
<th>Time</th>
<th>Expected Learning Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5 or CSA</td>
<td>Previously assigned FC and SLS group</td>
<td>5-6 mins per student</td>
<td>Individual student’s clinical skill level are assessed. Student groups receive general feedback on group performance indicating the strengths and skills that require further work. Students will receive their individual ratings 1-2 days later.</td>
</tr>
</tbody>
</table>

**Repeating a Step 5 (S5)/Clinical Skill Assessment (CSA)**

| Who | A student who has demonstrated an unsatisfactory performance (either Borderline – Unsatisfactory; or Unsatisfactory) in a S5/CSA. |
| **What** | The student will have up to 2 more times to revisit a particular skill set to allow them the opportunity to perform the skill at a satisfactory novice level. |
| **Where & When** | The time/location will be negotiated between the faculty member and student. Students will be given 3-10 working days before the reassessment unless another time has been discussed and mutually agreed upon by both the instructor and student. All SS will be completed on the Friday before the S6. If a student is later than 15 minutes after the session has started and without a valid explanation, this will register as an unsatisfactory attempt. |
| **Why** | Assessment for learning. |
| **How** | The student will be responsible for their own remedial work (however if they have questions, they are responsible for contacting the instructor). The student also recruits a fellow student to be the “patient” for the repeat assessment. The course coordinator will arrange for the student to be reassessed by a different FC when possible. The same checklist/equipment/environment will be used for the reassessment. The questions used will be up to the discretion of the Faculty Instructor. The student will be provided immediate feedback regarding skills demonstrated. The assessment checklist and rating will be submitted to the course coordinator for review. |
| **How Much** | Students must demonstrate satisfactory of skills at a novice for the skills assessed. **The student will be allowed three opportunities (i.e. 2 repeats) to demonstrate satisfactory performance at a novice level as required.** If a student does not achieve a satisfactory rating after the third attempt at the assessment, this will register as a fail for the clinical skills component of the course and therefore a failed course. These results will be discussed at a MPT Student Progress Committee meeting where the decision to offer a student a re-sit examination will be made. Students offered a re-sit will be charged for the costs of this student assessment. |
Assessing Clinical Skills

The MPT program uses two evidence-informed methods to assess clinical skills:

Competency-based, formative assessments (Kulasegaram & Rangachari, 2018; and Webb, 2018) identified these assessments as a teaching technique where students receive immediate feedback about the performance of clinical skills from a faculty member and no marks are attached to this assessment. In the MPT program, any student whose performance has been assessed as unsatisfactory or borderline (unsatisfactory) will discuss this performance with the instructor, and arrange together a reassessment. A student must pass both the written components and clinical skills assessment components of the course. A student is allowed up to 3 opportunities to receive a satisfactory mark in the clinical skills assessment. If a student does not achieve a satisfactory rating after the third attempt at the assessment, the student will register a fail in the clinical component (and therefore a fail in the course).

Objective Structured Clinical Examinations (Harden et al, 1975); (Terry et al, 2017) are summative and integrative assessment. An Objective Structured Clinical Examination (OSCE) uses a much more formal and summative method of assessing clinical skills. The OSCE is a standardized student assessment utilized with many health care professional programs. This clinical skills assessment utilizes a Standardized Patient (SP), a standardized checklist and a standardized setting to assess the student’s performance of applied physiotherapy knowledge, skills and attitudes. This assessment is included in the Student Learning and is called Step 6 (S6). The traditionally taught skills also are assessed by the S6/OSCE.

These summative and integrative assessments were designed to serve three broad purposes:

- to assess the students’ ability to integrate clinical skills from various course
- to screen students for unsafe clinical practice prior to entering clinical placements; and
- to mimic the diversity of clinical practice in the first clinical placements of neuromusculoskeletal (NMK), Cardiovascular pulmonary (CVP) and Neurology areas of care.

S6/OSCE includes six to ten minute stations. The questions require the student to integrate a broad range of clinical skills relevant to a specific case. These skills include:

1. communication skills
2. assessment or treatment of the particular case problem
3. patient education/feedback, and
4. safety
Students are required to pass four out of six stations with a minimum grade of C+ prior to proceeding to the clinical placement. In the event of failure of this component, the decision to offer a re-sit of the OSCE exam would be made at a follow-up Department of Physical Therapy (PT) student progress meeting.

Clinical Skills Assessment and the National Blueprint

The students enrolled in the PT Program, encounter clinical skills assessments which are similar but not identical to the Physiotherapy Competency Examination Blueprint 2009 (CAPR, 2009). Different areas of practice are covered in the clinical skills assessment, specifically in musculoskeletal practice; neurological practice; and cardiovascular pulmonary practice. As of 2019, there are no S6 stations in the MPT program covering a multisystem practice. In addition to these areas of care, PT Department S6 includes various fields of care (preventative, maintenance or restorative), different patient age groups and genders, and various practice settings (e.g., acute care facility, private practice, rehabilitation centre, community care and extended care facility) again, similar to the Physiotherapy Competency Examination Blueprint 2009. Refer to the Clinical Skills Assessment Working Group (CSAWG) Annual Report for the further information.
Stakeholders of Clinical Skills Assessments

Clinical Skills Assessments (CSA) involve a number of stakeholders including:

1. Students
2. Clinical Skills Assessment Working Group (CSAWG)
3. Year Coordinators (YC)
4. S6 Data Analyst
5. Course Coordinators
6. Faculty Instructors (FI)
7. Faculty Coaches (FC)
8. Standardized Patients (SP)
9. Classroom Technician; and
10. The CLSF staff

Each of these stakeholders has a particular role and set of responsibilities towards clinical skills assessments. The CSAWG has developed a checklist to keep stakeholders on track (see Appendix 1 CSAWG Working Checklist). The Department of PT endeavours to provide continuing education opportunities to all faculty members regarding evidence-informed student evaluation practices, which include the S5/CSA and S6/OSCE.

1. Students

Students receive an orientation to learning and assessment of clinical skills at the beginning of the MPT1 year.

**Student orientation to the S5/CSA:**
Course coordinators may describe how the S5/CSA runs, sample questions and marking rubrics prior to the assessment. Note, the sample questions could include the actual question.

**Students orientation to the S6/OSCE**
Four-six weeks prior to the event, students are provided with six clinical scenarios. In MPT1, four sample questions are provided for five out of the six clinical scenarios for students to practice. The sixth scenario does not include sample questions, but students are able to determine the relative
nature of the potential questions based on the first five samples of questions. In MPT2, students are provided with six clinical scenarios but not sample questions, only the outline of topics e.g., communication, patient/caregiver education, safety, and assessment/treatment. Each student is expected to participate in all clinical skills learning and assessment sessions. Students are encouraged to review their clinical skills performance as part of the formative education process.

2. Clinical Skills Assessment Working Group (CSAWG)

The CSAWG plans, administers and evaluates the summative, integrated assessments or OSCEs) and evaluates the formative clinical skills assessment (competency-based formative assessments) processes and outcomes in the MPT program. The working group reports to the Curriculum Review and Renewal Committee on an ongoing basis. The CSAWG membership includes:

1. Year coordinators for MPT1 and MPT2; and
2. One representative each from the NMSK, CVP and Neurology systems areas of teaching.

At the discretion of the chair, other faculty members with a substantial involvement or knowledge of the CSA process may be asked to participate e.g. a S6 data analyst.

The CSAWG chair shall be appointed by the Department Head. Working group decisions are made by consensus. Notes will be taken at every meeting and posted on S-drive. An annual report will be forwarded to the Curriculum Review and Renewal Committee.

The CSAWG is responsible for the following:

1. developing, reviewing and revising procedures for the competency-based, formative clinical skills assessments (S5/CSA).
2. developing, reviewing and revising procedures for the integrative and summative clinical skills assessment (S6/OSCE).
3. planning the MPT1 and MPT2 S6/OSCEs including:
   a. develop standardized questions and checklists (See Appendix 2).
   b. develop standardized patient/client scripts (See Appendix 3).
   c. determine equipment/room set up requirements in collaboration with instructors of the clinical skill (See Appendix 4).
4. Review overall MPT program S6/OSCE questions to ensure relevancy e.g. the breadth of clinical setting, gender, acuity and body system.

5. Maintain a bank of questions (S-Drive/PT/S6 Clinical Assessments/Working Documents Year)

6. Orient stakeholders (students, faculty coaches, and where indicated, standardized patients in collaboration with the Standardized Patient Coordinator) to the S6/OSCE process.

7. Maintain specific orientation materials for stakeholders:
   a. Students: Learning Clinical Skills document (department website, and MPT Year Syllabus) and student S6/OSCE Orientation Presentations (UM Learn and S-drive/PT/S6 Clinical Assessments/Orientation Presentations).
   b. Faculty coaches: Clinical Skills Assessment Handbook and Faculty Coach S6/OSCE Orientation Presentations (S-Drive/PT/S6 Clinical Assessments/Orientation Presentations);

8. Evaluate clinical skills assessment processes and outcomes.

9. Make recommendations to the Curriculum Review and Renewal Committee regarding clinical skills assessments (for example, which S6/OSCE questions to use) for the upcoming year through an annual report; and

10. Collaborate with the Program Evaluation Committee to contribute elements for departmental evaluation.

3. Year Coordinator (YC)

The role of the Year Coordinator (YC) is to coordinate specific tasks related to planning, administration and evaluation of MPT1 or MPT2 clinical skill assessments.

The YC is responsible for the following tasks:

1. Schedule S6/OSCE and Student Orientation sessions in timetable
2. Book CLSF (Clinical Learning and Simulation Facility), e.g. specific rooms, equipment required, computers and IT support for videorecording
3. Create/post exam schedule on UM Learn and bulletin board
4. Photocopy confidentiality forms (50 each), and video recording/release forms (50 each) for MPT1 students and have students complete these
5. submit confidentiality forms for the student files, and video recording/relase forms to CLSF
6. post S6/OSCE Scenarios questions (refer to Year Syllabus, Learning Clinical Skills document)
7. orient students to S6/OSCE
8. oversee the S6/OSCE

Prior to exam:
- connect with chair of Clinical Skills Assessment Working Group (CSAWG) to obtain OSCE information for the days of the OSCE.
- provide contact information to chair of CSAWG in case of faculty or SP inability to attend
- ensure contact information for all SPs is in the binder.

Day before exam:
- assist with equipment set-up prior to the exam as needed; noting any changes/additions to equipment list for the following year.
- put up door question outside and inside of room.

Early exam day:
- organize with the CLSF Program Administrator a quick review of using SIM IQ
- distribute Timer Script to timer
- organize a faculty coach (FC) “huddle” at the beginning of the day to reinforce FC responsibilities
- ensure all examiners and standardized patients (including back-ups) are present
- check regularly to see if examiners or SPs will be late/absent from exam
- if so, ensure back-up examiner or SP is ready to step in
- ensure all examiners have their station binder and two pens (on day 2 as well)
- ensure one copy of the door question is placed on the outside wall beside the door and one copy is placed on the table immediately inside the station
- ensure timer has script and is set up accordingly
- greet the students 10 minutes prior to the start of the exam
- check that all examiners and SPs are in appropriate stations and ready to start with doors closed 5 minutes prior to the start of the exam

With every new group of students:
- greet them 10 minutes prior to their scheduled start time
- usher them into the clsf approximately 3-4 minutes ahead of start time and show them where to deposit their personal items
- remind students of the university policy of no electronic devices and confidentiality
- orient students to the location of the stations and the flow of the stations
• hand out clipboards with clean paper and sharpened pencils
• inform the students of their starting stations
• have students advance to their starting station and face their back to the question. they will follow the directions of the timer who is voicing overhead.
• if a student is late, find another time in the schedule to accommodate that student (there are several free spaces throughout the exam)

Throughout the day:
• set up clipboards with new paper, sharpen and replace pencils as needed between groups
• clean up any discarded paper or equipment in the hallway
• ensure students are flowing through stations correctly (be present in hallway as they exit their station)
• check in with examiners and sps in breaks to check if back-up is needed. if not, sp back-up may leave one hour after start of the exam once told to stay close to their phones throughout the day. back-up examiner may leave once all examiners are present for the first rotation.
• liaise with clsf staff to ensure computer systems are working well.
• connect with examiners for any questions or to deal with: incident and incident reports and change of mark scores
• ask all examiners to complete feedback forms for students and to comment on checklists, door questions and scripts in their binder for the next year
• answer questions and connect with faculty coaches and sps throughout the day
• ensure examiners and sps are in place after breaks

End of day:
• debrief with fc to ensure the following information is submitted:
  o general feedback on sp and student
  o feedback on question, checklist, equipment and/or sp profile
  o any incidents
  o final request for changing marks
  o suggested revisions to the question, checklist or sp profile (comments on the paper copy of documents
  o faculty coach folders
• remove all door questions at end of day 2
• retain all station binders at end of day 2
• remove all equipment at end of day 2
• speak with clsf staff for all change of marks
• collate general feedback from all examiners about student performance, sp performance, and question/checklist performance and forward to CSAWG

9. review results of the S6 with CSAWG chair and S6 Data analyst; and
10. contact students who have either failed a station(s) or are demonstrating repeated areas of weakness. Arrange for meeting with the Course Coordinator.

4. **S6 Data analyst for Electronic Scoring**

The S6 data analyst is responsible for:
1. receiving results from the CLSF
2. reviewing and revising S6 results with CSAWG; and
3. posting student final results on UM Learn, PT6294, PT7294 OR PT7292.

5. **Course Coordinators**

Regarding the S5/CSA, the course coordinator is responsible for:
1. orient the S5/CSA procedures to students and faculty coaches
2. writing and posting a pre-S5/CSA student information on UM Learn
3. ensure that the S5/CSA questions are prepared by faculty
4. collate assessment questions, and provide assessment materials for faculty coaches; and
5. organize repeat assessments for students as required.

6. **Faculty Instructor (FI)**

The FIs who have taught the pertinent content will write the questions for these assessments. For the S6/OSCE, the FI may participate in a “dry run” where the trained SP will play the role. Together with the SP, the instructor will determine any last minute changes to script/equipment/room setup. The “dry run” is scheduled within the week of the OSCE.

7. **Faculty Coach (FC)**

The FC roles are to objectively and fairly assess the student clinical skills (S5/CSA and S6/OSCE) and provide feedback to the Course Coordinator regarding assessment content, process and student performance. The faculty coach is responsible for the following activities:

**S4/Review Lab:** Faculty coaches will use the same clinical skills approach as the primary faculty instructor as to not confuse students. Student Learning Strategy (SLS) groups will provide their completed confidence form to the FC at the Review Lab. The faculty coach will use this form to guide students practice of skills.
**Preparation for S5/CSA:** Course coordinators/instructors will send the marking rubrics to faculty coaches no less than three working days prior to send to assessment or review lab. It is essential that all faculty coaches review the rubric prior to assessment, especially external faculty coaches. Faculty coaches will also be given a one page handout on standardizing the S5/CSA process. Faculty coaches must be familiar with these materials and contact the instructor prior to the assessment if there are any questions.

**Day of S5/CSA:**

The procedure of this assessment is as follows:

- **student order selection:** students decide the order of student assessment prior to S5 by means of their own choice.
- **question selection:** students randomly select their question.
- **getting S5 started:** students are allowed 30-60 seconds to prepare equipment/space/read the question prior to being timed in the assessment. Students will have 5 or 6 minutes (dependent on the question) to demonstrate skills on a fellow student. Students will not be allowed to continue if they have reached the time limit other than to complete the skill they are working on (this up to the discretion of the faculty coach).
- **prompting the student during S5:** faculty coaches may only prompt students once stating "please reread the question”.
- **marking the student:** the faculty coaches use a standardized approach to the student clinical skills assessment based on an established rubric. The following criteria are used when marking a student’s performance:
  a. the skill level is at a novice level of student
  b. the safety* of the skills performed
  c. the student’s professional behavior*
  d. the student’s communication clarity/effectiveness
  e. the pace of performed skills; and
  f. if the student requires more exposure to learning the skills.

*Refer to examples of safety errors and non-professional behavior on Appendix 2.5

Student’s performance will be rated as **satisfactory or unsatisfactory.** There are **two categories of unsatisfactory performance:**

- if the student requires more exposure to learning the skills the student will be rated **borderline**
- if the student breached safety or professional behavior will constitute an **automatic unsatisfactory rating.**
In the instance where a faculty coach did not observe or recall the student performing a skill, the point will be given to the student. No skill will be marked after the time has lapsed. The faculty coach will indicate what the student did not do or did not do correctly on the marking rubric.

- **ending S5**: the student timer will provide a one minute warning to each student. Students will not receive credit for any skill performed after the time has ended. It is the faculty coach’s discretion whether or not the student may complete the skill if the time has elapsed.
- **feedback from faculty coaches**: faculty coaches provide verbal feedback to the group and individual students with the exclusion of individual students ratings. Individuals receive their marked rubric with particular feedback one to two days after the assessment.
- **consistency of faculty coach marking**: each S5/CSA will include a short debrief session where the faculty coach team can review marking practices. Faculty coaches submit their marked rubrics to the course coordinator or faculty instructor.

As mentioned previously, the S6/OSCE is a more formal assessment. The FC’s responsibility includes:

**Prior to S6/OSCE**: one to two weeks prior to the S6/OSCE, the FC will participate in the Faculty Coach S6/OSCE Orientation Presentation.

**Day of S6/OSCE**: the faculty coach has specific tasks to address:

- participate in the electronic marking orientation
- mark student performances
- request change of score if required
- identify student incidents to the YC
- provide feedback regarding:
  - student performance
  - checklist, question, and/or SP script performance
  - SP performance
  - other
- debrief at the end of the S6 with overseer

### 8. Standardized Patient (SP)

The Standardized Patient (SP) is an individual who has been trained in a specific patient role to reliably and consistently reproduce a history and or physical findings of typical cases. The use of standardized patients creates a clinically relevant and consistent setting for the evaluation of students and makes the examination as objective as possible. A backup SP is recruited to act on behalf of any of the other SPs if they are unable to attend the S6. If the SPs are all in attendance,
the backup SP may leave the event and will be paid for 3 hours of work but should be available the entire day. An SP is also recruited to act as a timer for the S6. The SP Coordinator is responsible for preparing the SP however the instructor will participate in a “dry run” after the SP is oriented to troubleshoot the script/equipment/room set up.

9. **PT Administrative Assistant**

The PT assistant plays a key supporting role in the administration of the S6/OSCE. Refer to Appendix 1 CSAWG Working Checklist for a description of this support, but in general, the PT assistant provides the majority of the CSAWG support within the last four weeks up until the S6/OSCE. The PT assistant collaborates with the chair regarding specific tasks to support the examinations. The PT assistant receives the dates of the S6/OSCEs at the beginning of each your in order to prepare materials. The assistant is also responsible for:

- reformating station questions and checklists
- confirming the student rotation schedules for MPT1 (Mike) and MPT2 (Liz)
- collating orientation materials for each faculty coach and producing an orientation binder
- producing a master binder(s) for the S6/OSCE overseer

10. **Classroom Technician and CLSF Technicians**

The classroom technician and CLSF technicians are sent an extensive room set up and equipment/supplies requirement three to four weeks prior to the S6/OSCE. Refer to Appendix 4 for further details.
Principle – Focused Evaluation and Reporting

The CSAWG chair provides a report including recommendations to the Curriculum Review and Renewal Committee every spring addressing the relevant information identified in the principles, questions and pillars within the Department of Physical Therapy Principle-vosuced evaluation program. The CSAWG utilizes the four pillars of the Department of Physical Therapy Program to evaluate the CSAWG activities: *effectiveness, accountability, sustainability and relevance*. The working group continues to be supported by Brian MacNeil, Mike McMurray and UM Learn to evaluate and make informed decisions around curriculum activities.

**Principle #1: The MPT curriculum is evidence-informed, richly interconnected with the health systems environment and graduates competent entry to practice physiotherapists.**

**Question:** Does the MPT program produce competent graduates?

<table>
<thead>
<tr>
<th>Indicator:</th>
<th>Source</th>
<th>Method</th>
<th>Pillar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program reflects current practice</td>
<td>CSA WG Report</td>
<td>Review of the relevance of questions e.g. practice setting, the clinical case demographics (age, sex, acuity, conditions)</td>
<td>Relevance</td>
</tr>
</tbody>
</table>

**Principle #2: The MPT program provides equitable opportunities and transparent processes in...student progression...**

**Question 1:** Do we provide equitable opportunities and transparent processes in student progression?

<table>
<thead>
<tr>
<th>Indicator 1:</th>
<th>Source</th>
<th>Method</th>
<th>Pillar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student assessment process is fair</td>
<td>S5 and S6/OSCE</td>
<td>Analysis of performance of clinical skills (student, S6/OSCE item and S6/OSCE station, safety)</td>
<td>Effectiveness</td>
</tr>
</tbody>
</table>
**Analysis of S5/Clinical Skills Assessment Results:** Student performance is analyzed throughout the academic year. After the academic year is complete, a summary of student performance is completed through the use of UM Learn statistics in grade book. UM Learn provides adequate statistical support for analysis including the mean scores, mode, standard deviation and student failures.

**Analysis of S6/OSCE Results:** The electronic results captured by SIM IQ are forwarded within 1 working day to S6 Data Analyst for initial collation and review. Using a department-designed analysis program, the S6 Data Analyst determines difficulty rating, and internal consistency per item within a question, mean scores, standard deviation and variance for each entire question; and analysis of subsections of student performance e.g. safety, communication, patient treatment/assessment and patient education/feedback. Members of the CSA Working Group and S6 Data Analyst for Electronic Scoring meet immediately after to discuss issues such as incidents, confidentiality, faculty coach feedback and results from the analysis of student and item/question performance.

a. **Station item performance:** The Department S6 software program designed by Brian MacNeil determines whether S6 checklist items are difficult (less than 20% of students answer correctly) (Schonwetter, 2006); moderately difficult (20-50% of students answer correctly) or are easy (greater than 50% of student answer correctly). Where it was determined that there were issues with, and the item was deemed to be difficult with poor discrimination, the checklist item may be temporarily removed or permanently removed. Where the student performance reveals an overall weakness in learning, the Year Coordinator/Instructor will make changes to the teaching strategy for the following year. The CSA WG may revise the questions and checklists for the following year given the recommendations.

b. **Analysis of Student Safety:** Safety in clinical practice is an important component of the S6. Cases and questions were designed to integrate the Canadian Patient Safety Institute definition of safety and Manitoban Clinical Instructor opinions regarding definitions of major and minor safety errors (Clinical Skills Assessment Report, 2007). There has been a distinction between minor and major safety errors: a major safety error is defined as a student error where harm is caused or there is a potential for harm. A minor safety error is defined as a student error where there is a remote chance of harm occurring. For the purposes of scoring students on their safe clinical performance, the working group designed the scoring checklist to include:
- Anticipated safety error clinical skills into the question scoring checklist. Prior to the 2014 report, reporting of these anticipated safety errors was inconsistent. For this reason, the 2014 and 2015 safety error numbers may appear higher than the errors reported in 2013.
- Unanticipated safety clinical skills. The question scoring checklist provided a section for the examiners to note these unanticipated safety errors, and marks would be deducted from the student’s overall score.

c. Student performance including failures: Student performance feedback may target particular skills (communication, safety, assessment/treatment, and patient education) as well as their overall mark for each particular station. Student failures are noted and a designated faculty member will follow up with students regarding this failure. Students will bear the additional costs associated with every re-sit examination (Supplemental Regulations, 2018).

d. Borderline Regression Method (BRM) and Global Rating Scales (GRS): S6 checklists are assigned an arbitrary pass grade of 65% which mirrors that for typical written exams. Given the differences between the S6 and written exam processes and the differences between the S6 stations, a method to assign a pass grade for each station was expanded to each station in the NMSK, CVP and Neurology S6 using a global rating scale using this Likert scale:

<table>
<thead>
<tr>
<th>Clear Fail</th>
<th>Borderline</th>
<th>Clear Pass</th>
<th>Very Good Pass</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The BRM includes analyzing:
- The mean score for the station.
- The pass mark that was generated using the borderline regression method which derives a passing grade based on the checklist scores and the global ratings. This process is intended to serve the same purpose as the Angoff method (specific for multiple choice questions). The BRM sets a pass mark based on the properties of the question rather than an arbitrary cut off (e.g., 65%).
- The number of failures based on the arbitrary cut off of 65%.
- The number of failures based on the BRM-derived cut off
- The number of students rated as ‘Clear fail’ on the global rating scale
- The number of students rated as ‘Borderline’ on the global rating scale.
e. **Comparison of Clinical Placement Performance and Academic Performance**: If warranted, clinical education performance and academic performance can be grouped into student performance indicators: Safety, Professional, Communication and Competencies.

**Principle #2: The MPT program provides equitable opportunities and transparent processes in...student progression... (continued)**

Question: Do we provide equitable opportunities and transparent processes in student progression?

<table>
<thead>
<tr>
<th>Indicator 2:</th>
<th>Source</th>
<th>Method</th>
<th>Pillar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student assessment process is fair; and Student academic progression is open and transparent</td>
<td>Faculty coach scoring patterns, Incidents, and Confidentiality</td>
<td>Review of course evaluations, student feedback, S6/OSCE incidents, and Review of Day 1/Day 2 OSCE results.</td>
<td>Accountability</td>
</tr>
</tbody>
</table>

**Faculty coach scoring variation**: Since the onset of the implementing the Student Learning Strategy in 2012, students have expressed concern regarding the variation of faculty coach scoring for S5 assessments. To address these concerns, standardized procedures were developed (2015) and faculty coaches were oriented to these. In 2018-19 in the MPT1 program, the S5/CSA were converted to competency-based formative assessments. Again, faculty coaches were oriented to this new approach. Faculty coaches have also been advised to not deviate from the faculty instructor’s approach to teaching clinical skills. The CSA WG continue to monitor this issue.

**Analysis of Incidents**: An incident is defined “as an occurrence with the personnel (Faculty Coach, student or standardized patient) or environment (incomplete equipment or supplies required for demonstration) which prevents or interferes with the student participating in the S6/OSCE station” (Modified Cooper, 2006). Upon the review of the incident, the CSA WG may:

- maintain the student station mark; or
- remove an item for the student or the entire class marks; or
- remove the station from the student or the entire class marks.
Where an entire station is removed for a particular student, the student may be offered to participate in a repeat S6 station, or the remaining S6 station scores may be averaged to determine the student’s S6 mark. *Note: prior to removing the station from the entire class marks, the CSA WG will discuss the issue with the Department Head.*

**Analysis of Confidentiality:** A S6 station or question may be entirely discarded if the faculty coach or CSA WG felt that the confidentiality of the question was compromised or an unforeseen event occurred (e.g. the examiner or standardized patient was unable to complete the entire S6 without having a replacement). The CSA WG may suspect a breach of confidentiality if the student scores on a particular S6 station show a trend of improving as the schedule continues.

**Principle #3: the MPT program exists in an environment that promotes wellness, and provides adequate resources to ensure its success**

**Question:** How does the environment support the success of the MPT program?

<table>
<thead>
<tr>
<th>Indicator:</th>
<th>Source</th>
<th>Method</th>
<th>Pillar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources are sufficient</td>
<td>CSA WG Report</td>
<td>Review of resources used in S6 / OSCE: CLSF venue, faculty coaches, standardized patients electronic scoring software, administrative support.</td>
<td>Sustainability</td>
</tr>
</tbody>
</table>
References


https://www.cmpa-acpm.ca/en/site-resources/glossary-of-terms#content-for-e


http://npag.ca/PDFs/Joint%20Initiatives/2017%20Competency%20Profile%20for%20PTs%20EN.pdf


https://www.who.int/patientsafety/en/
### Appendix 1: Clinical Skills Assessment Working Group Checklist

**LEGEND:**
- CSAWG – L. Harvey, M. McMurray, J. Parsons, G Hodges, B. Schorr (chair)
- PT Assistant – M. Thomas
- S6 Data analyst – B. MacNeil
- CLSF Program Administrator – M. Duval
- Year 1 Coordinator (YC1) – M. McMurray
- Year 2 Coordinator (YC2) – L. Harvey
- ACCE – M. Garrett
- SP Coordinator – M. Rudge

<table>
<thead>
<tr>
<th>Month</th>
<th>Tasks</th>
<th>Person Responsible</th>
<th>Date to be Completed</th>
<th>Status (✓)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan.</td>
<td>Review Faculty Coaches (FC) and Student orientation information</td>
<td>CSAWG</td>
<td>2-3 week of Jan</td>
<td></td>
</tr>
<tr>
<td>Jan.</td>
<td>Review OSCE materials</td>
<td>CSAWG</td>
<td>2-3 week of Jan</td>
<td></td>
</tr>
<tr>
<td>Jan.</td>
<td>Set date for FC orientation and forward date to PT Assistant Assign FC to stations including identification of back up FC.</td>
<td>CSAWG</td>
<td>2-3 week of Jan</td>
<td></td>
</tr>
<tr>
<td>Jan.</td>
<td>Complete the S6/OSCE student rotation</td>
<td>YC1 &amp; YC2</td>
<td>2-3 week of Jan</td>
<td></td>
</tr>
<tr>
<td>Jan.</td>
<td>Send date of MPT1 student OSCE orientation to PT Assistant.</td>
<td>YC1</td>
<td>2-3 week of Jan</td>
<td></td>
</tr>
<tr>
<td>Jan.</td>
<td>Forward SP request to SP Coordinator: <a href="mailto:marilyn.rudge@umanitoba.ca">marilyn.rudge@umanitoba.ca</a> / 204-250-1070 (mobile)</td>
<td>Chair</td>
<td>End of Jan</td>
<td></td>
</tr>
<tr>
<td>Feb.</td>
<td>Student OSCE orientation – YC1 receives confidentiality (1) and video recording forms (2) from PT Assistant.</td>
<td>PT Assistant &amp; YC1</td>
<td>Mid Feb.</td>
<td></td>
</tr>
<tr>
<td>Feb.</td>
<td>Set OSCE dates for next year – book set-up time for this and book weekend before to be free for students to practice</td>
<td>Chair, YC1 &amp; YC2</td>
<td>End of Feb</td>
<td></td>
</tr>
<tr>
<td>Feb.</td>
<td>Notify PT Assistant about NMSK &amp; Neuro OSCE question, checklist, SP profile, student rotation, and date of FC orientation</td>
<td>Chair</td>
<td>4 weeks before OSCE</td>
<td></td>
</tr>
</tbody>
</table>
| Feb.  | Post S6/OSCE materials on UM Learn: PT6294 & PT7292:  
- Student schedule  
- Post scenarios (+/- questions) | YC1 & YC2 | 4 weeks before |            |
<table>
<thead>
<tr>
<th>Month</th>
<th>Tasks</th>
<th>Person Responsible</th>
<th>Date to be Completed</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb.</td>
<td>• Orientation PPT Provide MPT1 &amp; 2 student orientation sessions (remind about confidentiality &amp; consent for video recording/releasing documents)</td>
<td>Chair</td>
<td>4 weeks before</td>
<td></td>
</tr>
</tbody>
</table>
| Feb.  | Send NMSK and NEURO OSCE checklists & schedule to:  
- CLSF Program Administrator  
- PT Admin Assistant  
- S6 data analyst | Chair | 3 weeks before | |
| Feb.  | Revise NMSK and NEURO OSCE equipment including names of FC. Send copy of OSCE equipment documents to CoRS Equipment Technician and CLSF. | Chair | 2 weeks before | |
| Feb.  | Collate NMSK and NEURO Master and Faculty Coach Binders | PT Assistant & Chair | 2 weeks before | |
| March | Receive and review CLSF formatted OSCE checklists for final versions. | Chair & Overseer | 2 weeks before | |
| March | Orient FC to NMSK and Neuro OSCE | YC1 or YC2 or Chair | 1 week before | |
| March | Hold dry run with SP’s | Instructors | Weekend before | |
| March | Set up OSCE in CLSF | CSAWG | Day before | |
| March | Oversee NMSK and NEURO OSCE:  
- Distribute Timer script to timer  
- Organize with CLSF Program Administrator a quick review of using SIM IQ  
- Organize a FC huddle at the beginning of the day to reinforce FC responsibilities  
- Hand out and retrieve clipboards, paper and pencils to students at the beginning/end of each OSCE round  
- Receive request to change scores and incidents from FC  
- Retrieve feedback from FC | YC1 | March | |
| March | Take down OSCE materials/equipment in CLSF | CSAWG | March | |
| March | Collect feedback from Faculty Coaches:  
Student performance general feedback  
S6 / OSCE materials (checklist, question, equipment, SP, incident forms, request to change mark forms) | YC1 & YC2 (or designate) | March | |
<p>| March | Analyze and finalize NMSK and NEURO OSCE marks | S6 Data analyst | Day after OSCE | |</p>
<table>
<thead>
<tr>
<th>Month</th>
<th>Tasks</th>
<th>Person Responsible</th>
<th>Date to be Completed</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>Notify MPT1 &amp; MPT2 cohorts and ACCE of who is cleared to attend placement</td>
<td>Designated members CSAWG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>Notify individual students if: Station(s) failed A major safety error is committed S6/OSCE failure</td>
<td>Chair</td>
<td>Day after OSCE</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>Collate NMSK and NEURO OSCE Student Performance General Feedback and post on PT6291 and PT7292 UM Learn.</td>
<td>YC1 &amp; YC2</td>
<td>Within 1 week after</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>Post NMSK and NEURO OSCE Marks on PT6291 and PT7292 UM Learn Upload scoring spreadsheets to S-drive (Administrative Documents-not for edits)</td>
<td>S6 Data analyst</td>
<td>Within 1 week after</td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>Review the clinical skill assessments results from the past year, including: CVP, NMSK &amp; NEURO S5/Clinical Skills Assessment CVP, NMSK &amp; NEURO S6/OSCE’s (questions, SP selection, equipment, room selection, FC, OSCE processes including student and FC orientations)</td>
<td>CSAWG</td>
<td>First 1-2 weeks April</td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>Draft recommendations for next year: questions procedures</td>
<td>CSAWG</td>
<td>First 1-2 weeks April</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>Write and submit CSAWG report to CRRC including recommendations</td>
<td>Chair &amp; CSAWG</td>
<td>1st week May</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>Revise Year Syllabi information for next year as required.</td>
<td>Chair</td>
<td>Mid May</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>Select FC for all OSCE’s including back up FC and insert into timetable.</td>
<td>CSAWG and YC1 &amp; 2</td>
<td>End of May</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>Write next OSCE questions, SP profiles checklists, and equipment lists for following year.</td>
<td>CSAWG and Instructors</td>
<td>1st week June</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>Forward CVP SP requests &amp; profiles to SP Coordinator</td>
<td>Chair</td>
<td>Last week June</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>Review FC and Student orientation information</td>
<td>CSAWG</td>
<td>Last week June</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>Review OSCE materials</td>
<td>CSAWG</td>
<td>Last week June</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>Complete the CVP S6 / OSCE student rotation</td>
<td>YC2</td>
<td>Last week June</td>
<td></td>
</tr>
<tr>
<td>July</td>
<td>Request MPT1 student pictures to be sent in CLSF approved format</td>
<td>PT Assistant</td>
<td>1st week</td>
<td></td>
</tr>
<tr>
<td>Month</td>
<td>Tasks</td>
<td>Person Responsible</td>
<td>Date to be Completed</td>
<td>Status</td>
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<tr>
<td>Aug.</td>
<td>Meet as required to complete S6/OSCE material revisions</td>
<td>CSAWG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aug.</td>
<td>Notify PT Assistant about CVP OSCE question, checklist, SP profile, student rotation and date of FC orientation.</td>
<td>Chair</td>
<td>1st week Aug.</td>
<td></td>
</tr>
<tr>
<td>Sept.</td>
<td>Send CVP OSCE checklists &amp; schedule to CLSF Program Administrator and copy message to S6</td>
<td>Chair</td>
<td>4 weeks before</td>
<td></td>
</tr>
<tr>
<td>Sept.</td>
<td>Send CVP OSCE equipment to CoRS Equipment Technician and CLSF</td>
<td>Chair</td>
<td>3 weeks before</td>
<td></td>
</tr>
<tr>
<td>Sept.</td>
<td>Collate CVP Master and Faculty Coach Binders</td>
<td>PT Assistant &amp; Chair</td>
<td>2 weeks before</td>
<td></td>
</tr>
<tr>
<td>Sept.</td>
<td>Orient FC to CVP OSCE</td>
<td>YC2 or Chair</td>
<td>Week before</td>
<td></td>
</tr>
<tr>
<td>Oct.</td>
<td>Dry run with SP</td>
<td>Instructors</td>
<td>Week before</td>
<td></td>
</tr>
<tr>
<td>Oct.</td>
<td>Set up OSCE in CLSF</td>
<td>CSAWG</td>
<td>Day before</td>
<td></td>
</tr>
<tr>
<td>Oct.</td>
<td>Oversee CVP OSCE: Distribute Timer script to timer. Organize with CLSF Program Administrator a quick review of using SIM IQ. Organize a FC huddle at the beginning of the day to reinforce FC responsibilities. Hand out and retrieve clipboards, paper and pencils to students at the beginning/end of each OSCE round. Receive request to change scores and incidents from FC. Retrieve feedback from FC.</td>
<td>YC2</td>
<td>October</td>
<td></td>
</tr>
<tr>
<td>Oct.</td>
<td>Oversee CVP OSCE</td>
<td>YC2</td>
<td>October</td>
<td></td>
</tr>
<tr>
<td>Oct.</td>
<td>Collect feedback from Faculty Coaches: Student performance general feedback</td>
<td>YC2 (or designate)</td>
<td>October</td>
<td></td>
</tr>
<tr>
<td>Month</td>
<td>Tasks</td>
<td>Person Responsible</td>
<td>Date to be Completed</td>
<td>Status</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------</td>
<td>-----------------------------------------</td>
<td>----------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Oct.</td>
<td>S6 / OSCE materials (checklist, question, equipment, SP, incident forms, change of mark request forms)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct.</td>
<td>Take down OSCE materials/equipment in CLSF</td>
<td>CSAWG</td>
<td>October</td>
<td></td>
</tr>
<tr>
<td>Oct.</td>
<td>Analyze and finalize CVP OSCE marks</td>
<td>S6 Data analyst, Designated members CSAWG</td>
<td>Day after</td>
<td></td>
</tr>
<tr>
<td>Oct.</td>
<td>Notify MPT2 cohort and ACCE of who is cleared to attend placement</td>
<td>Chair</td>
<td>Day after</td>
<td></td>
</tr>
<tr>
<td>Oct.</td>
<td>Notify individual students if: Station(s) failed A major safety error is committed S6/OSCE failure</td>
<td>YC2</td>
<td>Day after</td>
<td></td>
</tr>
<tr>
<td>Oct.</td>
<td>Collate CVP OSCE Student Performance: General Feedback and post on PT7291 UM Learn.</td>
<td>YC2</td>
<td>Within 1 week after</td>
<td></td>
</tr>
<tr>
<td>Oct.</td>
<td>Post CVP OSCE Marks on PT7291 UM Learn Upload scoring spreadsheets on S-drive (Administrative Documents-not for edits)</td>
<td>S6 Data analyst</td>
<td>Within 1 week after</td>
<td></td>
</tr>
<tr>
<td>Oct.</td>
<td>Send CLSF Program Administrator the following information for SSIM IQ set up: MPT1 student names, UM ID, student numbers, and a single zip file (.zip, .rar, 7z, etc.) containing all user photos with each image (saved as .jpg, .jpeg, .png, or .bmp, and named either by student number OR lastname, firstname (no space after comma). An example of the format is: 012345.jpg OR Smith,Jane.jpg</td>
<td>Chair</td>
<td>Early Oct.</td>
<td></td>
</tr>
<tr>
<td>Nov.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2: Creating the Standardized Station in the S6/OSCE

Designing a S6 question involves creating a question, scoring checklist for the Faculty Coach and case notes or script for a standardized patient (SP). The question should be brief and clear and be able to fit on one page. Developing the S6 question involves:

1. identifying the skill to be tested in a question
2. writing the door question
3. writing the weighted checklist
4. requesting feedback from the CSAWG concerning the question / weightings

Identification of the Skill to be Tested:
Prior to writing a question, define the purpose of the question in order to direct your question development. Examples are in italics:

   a. to test student’s education skills about physical activity post MI
   b. to test student’s assessments skills when performing a lumbar scan
   c. to test the student’s skills in treating the arm of a neurologically impaired person.

Write the Door Question

   a. **Designate a title which will includes the condition, what is expected of student and the practice setting.** Examples are in italics:

      - *Post Myocardial Infarction: Treatment (Acute Medical Ward, Hospital)*
      - *Low Back Pain: Patient Education (Private Practice)*
      - *Heal Injury: Assessment (Community Program)*

   b. **Provide a scenario of the station:** Include appropriate background information required for the student to perform the station (omitting extraneous information not relevant to the question). This could include the general patient description, medical history, symptoms, present mobility, and descriptions of any tests or assessments previously performed on the patient.

   c. **Describe what the students are expected to perform:** Include the skills you expect the students to demonstrate, having this stand out in the instructions. This could be limited to history taking, patient education, assessment or treatment skills, or any combination of these.
Appendix 2.1 Examples of Scenarios and Student Expectations are In Italics:

Example 1:

*Daniel Ramsey is a 60 year old patient who has been admitted to the hospital for the treatment of a myocardial infarct. This is his first hospital admission, and it has been uneventful. He has been active on the ward and has received cardiac education from all team members. Medications include anti-hypertensive and sublingual nitro-glycerine tablets. His discharge home is planned for tomorrow to a 1 storey bungalow in Winnipeg.*

*Demonstrate the pre-discharge stairs assessment as well as reinforcement of his action plan should he experience angina at home.*

Example 2:

*Jennifer Penn is a 35 year old patient who presents with low back pain after lifting a box at work 3 days ago. She has been unable to return to work due to pain. Two years ago she injured herself lifting 2 years ago. She reports pain increased with coughing and sitting or standing longer than 20 minutes.*

*Demonstrate the supine components of the lumbar scan.*

Example 3:

*Jason Plaknic is a head injured patient at a rehabilitation center. He sustained his head injury one month ago in a MVA. His memory and concentration are poor. He is not walking yet and demonstrates poor trunk control.*

*Assist him with moving into 4 point kneeling and perform 2 exercises / activities in this position to improve his trunk control. End the session by assisting him back into sitting on the side of the bed.*
d. **List the skill sets that the station evaluates.** These include: Communication Skills, Assessment and Treatment Skills, Patient Education and Feedback, Safety in Clinical Practice.

e. **Indicate the time frame** to complete the practical component of the station.

   *YOU HAVE (10) MINUTES*

f. **Indicate if a post-encounter question** accompanies the station and the time allocated (e.g. 5 and 5 minutes).
Appendix 2.2 Example of Completed Door Question:

| Deconditioning: Treatment of Range of Motion  |
| (Pulmonary Rehabilitation)                  |

Mr. Ford is a 62 year old man with newly diagnosed emphysema. As part of his outpatient respiratory rehabilitation program, you have chosen some stretches to include in his exercise session.

Teach this patient to perform the following static stretching exercises on the left side. Give him specific information about how he is to do these as part of his home program.

1. Hamstring stretch (sitting on floor)
2. Hip flexor stretch (in standing, both feet on floor)

SKILLS BEING EVALUATED:

Communication Skills
Assessment and Treatment Skills
Patient Education and Feedback
Safety in Clinical Practice

YOU HAVE 10 MINUTES
Appendix 2.3 Template For Door Question:

<table>
<thead>
<tr>
<th>TITLE: (Arial Font, Size 12, Italics, and Centred)</th>
</tr>
</thead>
</table>

Scenario: (Arial font, size 12, italics, left margin alignment) to include patient name, age and clinical setting (eg outpatient clinic, hospital ward, etc). Should also include appropriate background information required for the student to perform the station. This could include the general patient description, medical history, symptoms, present mobility and description of any tests or assessment previously performed on the patient.

Description of what the students are expected to perform (Arial, size 12, italics and bold). This should include skills you expect the students to demonstrate. This could be history taking, patient education, assessment/treatment skills or any combination of these.

SKILLS BEING EVALUATED: (ARIAL, SIZE 12, ITALICS, TITLE IN CAPITALS AND BOLD)
(List of one or any combination of the following skill sets – italics, not bold):

- Communication Skills
- Assessment and Treatment Skills
- Patient Education and Feedback
- Safety in Clinical Practice

YOU HAVE 10 MINUTES (ARIAL, SIZE 12, ITALICS AND BOLD)

Note: INDICATE IF A POST-ENCOUNTER QUESTION ACCOMPANIES THE STATION AND THE TIME ALLOCATED.
Write the Weighted Checklist

The weighted question checklist is an evaluation tool that utilizes objective responses in order to evaluate the student’s clinical knowledge in the station question. The use of skill sets allows the different components of an interaction during an OSCE to be separated and viewed to provide feedback to the instructor and student. The student is able to see their strengths and weaknesses, and make improvements based on their results, therefore increasing the value of the examination.

1. **Describe clear and objective responses to the question**
   The instructor should write a checklist that includes descriptive responses which breakdown what the student is required to perform. The question and checklist should be written with the intent that a back up examiner would have no difficulty in interpreting the checklist item and desired responses. The instructor is encouraged to have colleagues review the language used in a checklist to ensure clarity and objectivity.

   Using words such as *appropriate* in a checklist item (for example, Appropriate handling techniques), *correct* (ex. Performs correct procedures), and *optimal* (ex. Wheelchair in optimal position) without further clarification are unclear and should be expanded to include specific behaviors. For example, instead of working “appropriate handling technique” a more specific wording is, “positions the hands to support above and below knee joint throughout the exercise”. In certain instances, the instructor may write a guideline for the examiner to assist in the interpretation of a checklist item.

   Note: the checklist and standardized patient script will be written in a manner in which the student interacts exclusively with the standardized patient. The OSCE question checklist will not include verbal questions from the examiner.

2. **Cull the number of responses to be a suitable number**
   An OSCE checklist template has been developed and is to be used for all exams. A 10 minute station requires a total of 25-30 checklist items and a 5 minute station requires a total of 8-25 checklist items (Modified Cooper, 2006). See Sample Checklist below. The checklist responses must be also categorized into the appropriate skill sets.

   a. Communication skills section reflects a standardized template of responses that each OSCE utilizes to assess student’s communication skills (See checklist template on Appendix 2.4). These responses have been discussed and approved by Faculty.

   b. Assessment and/or treatment skills section includes skill sets that evaluate the students’ performance of assessment and/or treatment core material. This includes components of a particular assessment or treatment that is broken down into an objective list of what is expected of students to perform. Examples are in italics:
      i. *Explains importance of breathing exercises*
      ii. *Teaches effective deep breathing*
      iii. *Performs active straight leg raise*
      iv. *Provides mobilization to increase knee flexion*
v. Performs activities to improve balance in sitting
vi. has patient perform deep breathing exercises in sitting

c. Patient education and feedback skills section evaluates the student’s ability to provide the patient with appropriate education and feedback during the intervention. The checklist template outlines the following items to be included:
   i. Confirms patient understanding during the intervention/assessment;
   ii. Teaches appropriate technique; e.g. When prescribing an exercise, student indicates the correct number of repetitions, sets and frequency
   iii. Answers questions appropriately; and
   iv. The Instructor may add specific bubble(s) appropriate to the question as well as including anticipated error as appropriate.

d. The safety skills section requires special attention by the instructor. Some S6/OSCE questions do not lend themselves to have safety items while other questions require the student to pay particular attention to safety during assessment or treatment of the standardized patient. Safety section evaluates the students’ ability to ensure patient safety is not compromised throughout the interaction. Patient safety is defined as:

   “Patient safety is the absence of preventable harm to a patient during the process of health care and reduction of risk of unnecessary harm associated with health care to an acceptable minimum. An acceptable minimum refers to the collective notions of given current knowledge, resources available and the context in which care was delivered weighed against the risk of non-treatment or other treatment” (World Health Organization, 2019).

The Faculty Instructor includes the anticipated and specific safety items relevant to the case when writing the Patient Safety section (e.g. tests for hot/cold sensation prior to applying the electro-physical agent on the patient). The inclusion of anticipated safety items in a checklist provides the student the opportunity to receive credit for performing the skill in the expected and safe manner. In the instances where a student makes an unanticipated error which causes harm, a near miss, no harm, the skill will be deemed unsafe and marks will be deducted from the overall station score.

The checklist template outlines the following Patient Safety items to be included:
   i. Infection control/routine practices - Washes hands prior to and after touching the patient
   ii. Uses good body mechanics

---

1 Error is defined as, “an act (plan, decision, choice, action or inaction) that given the information available and the patient’s clinical condition at the time, was done wrongly or performed incorrectly in those circumstances, and therefore resulted in an adverse event or near miss” (CMPA, 2019).
2 Harm is defined as, “an impairment of structure or function of the body and/or any deleterious effect arising therefrom. Harm includes disease, injury, suffering, disability and death”. A harmful event is defined as, “a patient safety incident that resulted in harm to the patient (Canadian Patient Safety Institute, 2019).
3 A near miss is defined as, “a patient safety incident that did not reach the patient and therefore no harm resulted”, (Canadian Patient Safety Institute, 2019).
4 No harm incident is defined as, “a patient safety incident that reached the patient but no discernible harm resulted”, (Canadian Patient Safety Institute, 2019)
iii. The Instructor may add specific bubble(s) appropriate to the question, e.g. Contraindications assessed specific to the station; equipment is prepared to ensure patient safety, etc.

iv. The Instructor may also add anticipated safety items as appropriate.

3. Assign weightings to each checklist item

Once the checklist is completed, the instructor determines how many marks are allotted to each checklist item. A marking rubric has been standardized for all OSCE questions for the Communication skills section as well as a number of other items in the Assessment/Intervention, Patient education and feedback, and Safety skills sections (See checklist template on Appendix 2.4).

The checklist is designed so that a student receives marks for successfully performing the task related to the item on the checklist. Some items are more difficult to perform than others and accordingly will be assigned a higher weighting (e.g. donning a transfer belt on a client or demonstrating a particular hand placement to perform a ligament test). Some items will be easier to perform but play an integral part of the performance of a task (e.g. stating the purpose of a physical therapy intervention or closing an interaction with a client). A lower weighting is assigned to the easier tasks. The checklist will therefore display a variety of weightings anywhere from .5 scores and up.

In the event that a student makes an unanticipated safety error the examiner will make a judgment about whether the seriousness of the error taking into consideration if the error caused harm or no harm (close call). Examples of serious or major errors and a less serious or minor errors are found on Appendix 2.5. An unanticipated major safety error is weighted 25% of the total S6/OSCE question marks (e.g. if the total marks of the station add up to 32 excluding the anticipated major infraction, the major infraction would be weighted a score of 8). An unanticipated minor safety error is weighted 10% of the total OSCE question marks (e.g. if the total marks of the station again add up to 32 excluding the anticipated minor infraction, the minor infraction would be weighted a score of 3). A marginal safety error (e.g. failure to wash hands) may be weighted as low as 3% of the total S6/OSCE question marks and may not be necessarily categorized as a minor infraction. Once the weightings of each response have been determined, the total exam score is placed at the top of the left hand side of the checklist.

The weighting of safety errors is designed to avoid a situation where there are automatic student failures. The stronger student who commits a safety error may not fail the station however the overall
score may be a low passing score. The weaker student committing either a safety error may cause the overall score to be a failure for the station.

Note that **not all safety errors can be anticipated on checklists**. In the event that a student performs an unsafe technique or explains something in an unsafe manner which has not been anticipated/not identified on the checklist, the examiners will describe the safety error in the section following the Comment Box. Where a student makes a minor safety error, 10% of the total question score is deducted from the overall station score. Where a student makes a major safety error, 25% of the total score is deducted from the overall station score.
## Appendix 2.4 Template of Weighted Checklist

**TITLE:** (Bold, Capitals, Arial Font Size 9)  
**COURSE NUMBER** (Bold, Capitals, Arial Font Size 9)  
**Score:** /Total (Arial Font Size 9)

<table>
<thead>
<tr>
<th>SCORE</th>
<th>TITLE OF QUESTION - SKILL SETS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COMMUNICATION</td>
</tr>
<tr>
<td></td>
<td>Introduces self (including name and title: student physiotherapist)</td>
</tr>
<tr>
<td>1</td>
<td>Obtains consent:</td>
</tr>
<tr>
<td></td>
<td>• Explains the general purpose of interaction, the procedures to be used and potential adverse effects (including normal and abnormal responses).</td>
</tr>
<tr>
<td>1</td>
<td>• Verifies patient’s basic understanding of the procedure (Do you have any questions?).</td>
</tr>
<tr>
<td>1</td>
<td>• Asks/obtains consent for assessment/treatment once purpose is explained.</td>
</tr>
<tr>
<td>1</td>
<td>Instructions and/or information are clear, concise and accurate.</td>
</tr>
<tr>
<td>1</td>
<td>Uses appropriate language throughout the exchange with the patient.</td>
</tr>
<tr>
<td></td>
<td>Actively listens – for history questions</td>
</tr>
<tr>
<td>1</td>
<td>Demonstrates professional and respectful behavior.</td>
</tr>
<tr>
<td>1</td>
<td>Closes interaction with patient.</td>
</tr>
<tr>
<td></td>
<td>ASSESSMENT AND/OR TREATMENT</td>
</tr>
<tr>
<td>Variable</td>
<td>• Instructor adds specific bubble(s) appropriate to the question.</td>
</tr>
<tr>
<td></td>
<td>PATIENT EDUCATION AND FEEDBACK</td>
</tr>
<tr>
<td>Variable</td>
<td>Confirms patient understanding during the intervention/assessment.</td>
</tr>
<tr>
<td>10% or 25%</td>
<td>? applicable to history question</td>
</tr>
<tr>
<td></td>
<td>Teaches appropriate technique:</td>
</tr>
<tr>
<td></td>
<td>• Instructor adds specific bubble(s) appropriate to the question</td>
</tr>
<tr>
<td>10% or 25%</td>
<td>• Instructor may add anticipated infraction(s) appropriate to the question</td>
</tr>
<tr>
<td></td>
<td>Answers questions appropriately:</td>
</tr>
<tr>
<td>Variable</td>
<td>• Instructor adds specific bubble(s) appropriate to the question</td>
</tr>
<tr>
<td>10% or 25%</td>
<td>• Instructor may add anticipated infraction(s) appropriate to the question</td>
</tr>
<tr>
<td></td>
<td>SAFETY</td>
</tr>
<tr>
<td>1</td>
<td>Infection control/routine practices - Washes hands prior to and after touching the patient.</td>
</tr>
<tr>
<td></td>
<td>Uses good body mechanics:</td>
</tr>
<tr>
<td>Variable</td>
<td>• Instructor adds specific bubble(s) appropriate to the question</td>
</tr>
<tr>
<td>10% or 25%</td>
<td>• Instructor may add anticipated safety item(s) appropriate to the question</td>
</tr>
</tbody>
</table>
| Variable | Advises patient to let student know if the patient is experiencing any untoward responses.  
*Instructor lists specific responses* |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable</td>
<td>Ensures patient safety at all times - ? if applicable for a history question</td>
</tr>
<tr>
<td>10% or %25</td>
<td><em>Instructor adds specific bubble(s) appropriate to the question.</em></td>
</tr>
<tr>
<td>10% or %25</td>
<td><em>Instructor may add anticipated errors appropriate to the question</em></td>
</tr>
</tbody>
</table>

Comments

Unanticipated Major Safety Error (____ marks)
1. __________________________________________ 2. __________________________________________

Unanticipated Minor Safety Error (____ marks)
1. __________________________________________ 2. __________________________________________
Appendix 2.5 Examples of Safety Errors

The following examples of safety errors reflect information taught in various courses. It is not an exhaustive list of errors.

Major Safety Error (the action caused or could cause harm to the patient)

1. Failure to perform appropriate ligament stability and artery tests (CV/VAT) prior to spinal manual therapy.
2. Leaving a patient who is unsteady in any position.
3. Improper use of equipment or improper education of a patient in its use, thereby putting the patient at risk for harm.
4. Failure to screen sensory function prior to the application of thermal modalities.
5. Inadequate knowledge base regarding the contraindications or precautions in assessment or intervention, e.g. incorrect activity information following a medical event such as an MI or CABG; movement precautions with THR; or inappropriate prescription of exercises with respect to healing of tissues.
6. Not standing close enough/assisting enough when patient is ambulating, or attempting to lift an individual alone when body weight requires 2 assistants.
7. Unsafe transfer or PT technique where patient not fully supported and potential for falls/unsteady postures will quickly occur.
8. Lack of observation or response to symptoms of distress and need to discontinue treatment, e.g. profuse diaphoresis in exercise, skin breakdown with frictions.
9. Continuing treatment when patient (or standardized patient, SP) complains of increasing symptoms (e.g. above and beyond those requested as part of the SP’s script).
10. Unprofessional behavior, for example, exhibited poor use of language, word choice, was disrespectful to patient or used racial slur, or inappropriate dress.
11. Lack of recognition of an appropriate cultural sensitivity to the patient.
12. Sensitive practice errors e.g. inappropriate physical contact with client, improper draping, ask permission to touch the client.
13. Information to patient was inaccurate and caused physical or psychological harm.

Minor Safety Error (the action caused no harm or a “near miss”)

1. Prescription of bed client exercises that was too advanced or inappropriate for the patient’s physical capabilities.
2. Lack of observation patient doing a prescribed home exercise program.
3. Incorrect body mechanics/positions for himself/herself or the patient.
4. Failure to communicate to patient that the patient may experience symptoms (e.g. soreness) after assessment or treatment.
5. Information to patient was inaccurate and caused physical or psychological harm.
4. **Submit the checklist for review:** When the checklist is completed, CSAWG member submits the question including weightings and checklist to the WG for review. The WG will use consensus to decide on the final version of the question. A Question Review Form (Modified Cooper, 2006) is a tool to enhance feedback (see below). The WG member may make any revisions required and resubmits the final checklist to the WG.
S6/OSCE QUESTION REVIEW FORM

Station Name:  Instructor:

1. Instructions to Candidates:
   a. Clarity
   b. Brevity
   c. Accuracy
   d. Completeness
   e. Could I answer the questions

   Examiner’s checklist
   Clarity
   f. Brevity
   g. Accuracy
   h. Completeness
   i. Scoring
   j. Connection to student instructions
   k. Connection to SP instructions

   Notes to Examiners  Not applicable: N/A
   l. Clarity
   m. Brevity
   n. Completeness
   o. Necessary?

2. Is the written question is connected to the clinical encounter?

3. Written questions  N/A
   a. Clarity
   b. Brevity
   c. Appropriate short answer
   d. Completeness of answer key
   e. Scoring

4. SP Instructions
   a. Clarity
   b. Completeness
   c. Organization
   d. Connection to checklist

5. Other Comments
Appendix 3: Writing a Standardized Patient Simulated Profile

Preparing the Simulation Profile

Three months prior to the 56/OSCE, the CSAWG prepares the simulation profile notes to reflect the role to be portrayed by the standardized patient. A blank copy of this template is available on S drive / Physical Therapy, Standardized Patient Forms / Simulation Profile 14 OCT 15.

Two months prior to the 56/OSCE, these profile notes are then reviewed by the CSAWG for quality assurance purposes. The review considers the OSCE question and the checklist. Since the MPT program inception, many simulated profiles have been developed whereby different versions of the stem scenarios could be developed to coincide with different OSCE questions. Points to keep in mind when developing the case:

- The CSAWG will discuss the overall scenarios used in the MPT Program to ensure that these scenarios reflect different practice areas, clinical settings, patient demographics, and clinical conditions. If there is a gap in one of these areas, then a new scenario will be developed.
- Once a new scenario has been approved, then the question and SP role is developed. The role that is being portrayed is to reflect a “real” patient situation so that students are able to better engage in the interaction with a “patient.” So consequently we need to provide as much information as possible for the standardized client to portray the role we expect.
- The simulation profiles are for the actors, not for faculty members. As content experts, we can visualize the patient, the setting, the expected interaction. However, we often omit relevant details that allow the actor to portray a “real” patient. Without this degree of detail, there cannot be standardization because the actor has not been provided with enough detail and often may have to “make-up” information or interactions.
- As you look at the simulation profile template, there will be items that would not apply to the clinical situation for your education / examination process. Rather than insert N/A, simply remove the item. Rather than refer to the patient as “you should …” address them as “Mr. Brown has shortness of breath with very little activity.” Also if you are not wanting actors to react a certain way to an interaction, provide them with that information.
Training the Standardized Patient

**Six to eight weeks prior** to the OSCE, the Chair, CSAWG completes the *SP Request Form (S-drive / PT / Standardized Patient Forms, CRS-SC Request Form)* and forward this to the Standardized Patient Coordinator including:

- How many SPs and back up SPs are required including inclusion/exclusion critiera
- Specific SPs where possible
- Date/Time of the OSCE
- Date/Time of a dry run
- All simulation profiles

The Standardized Patient Coordinator will proceed to orient the SPs to their roles prior to the exam unless otherwise indicated. One week prior to the S6/OSCE the instructors will review the role with the SPs during the dry run.
### Appendix 4: Equipment Requirements

<table>
<thead>
<tr>
<th>CLSF ROOM</th>
<th>Station number</th>
<th>Scenario Name</th>
<th>Faculty Coach (FC)</th>
<th>Standardized Patient (SP)</th>
<th>CLSF Equipment and Room Set up</th>
</tr>
</thead>
</table>
|           |                |                            |                    |                           | Red font: CLSF responsible  
|           |                |                            |                    |                           | Black font: CSAWG responsible  |
| Each room |                |                            |                    |                           | • Small table with chair with laptop on table  
|           |                |                            |                    |                           | • Silver instrument tables just inside the room (for student questions)  
|           |                |                            |                    |                           | • Hand sanitizer and tissues  
|           |                |                            |                    |                           | • Video-recording  
|           |                |                            |                    |                           | • Overhead announcements  |
| #14       | Station 1 – Gray (Thoracotomy) | FC - Greg  
|           |                |                            | SP – Xiam           |                           | • Hospital bed positioned so that the patient’s left side is against the wall.  
|           |                |                            |                    |                           | • Bedding, 3 pillows, nasal prongs oxygen tubing to wall outlet,  
|           |                |                            |                    |                           | • IV to IV pole, PCA set up on patient’s right arm,  
|           |                |                            |                    |                           | • NOTE: No chair for patient to sit on.  
|           |                |                            |                    |                           | • Chest tube on left chest, and drainage system positioned at the foot of bed (PT department if not in CLSF)  
|           |                |                            |                    |                           | • Foley catheter  
|           |                |                            |                    |                           | • Bedside with tissues (for students to be able to put clipboard and stethoscope down)  
|           |                |                            |                    |                           | • Surgical tape over incision site and chest drainage,  
|           |                |                            |                    |                           | • Foot stool  
|           |                |                            |                    |                           | • Hospital gown  
|           |                |                            |                    |                           | • PJ bottoms (SC to bring)  |
| #13       | Station 2 – Right (Pre-op CABG) | FC – Cyndi  
|           |                |                            | SP – Frank          |                           | • Hospital bed  
|           |                |                            |                    |                           | • 2 pillows and sheet on table/plinth  
|           |                |                            |                    |                           | • Extra pillow on table  
|           |                |                            |                    |                           | • Foot stool  
|           |                |                            |                    |                           | • Small table  
|           |                |                            |                    |                           | • 2 chairs (not with wheels)  
|           |                |                            |                    |                           | • Clipboard  
|           |                |                            |                    |                           | • Blank paper (30 sheets) and 2 pencils  |
| #12       | Station 3 – Denis (Post MI) | FC – Nancy  
|           |                |                            | SP – Rick           |                           | • Hospital bed with bedding  
|           |                |                            |                    |                           | • 2 pillows  
|           |                |                            |                    |                           | • Clipboard  
|           |                |                            |                    |                           | • Small table for equipment  
|           |                |                            |                    |                           | • Long sleeved shirt to cover heart rate monitor  
|           |                |                            |                    |                           | • 2 Stop watches, 2 polar heart rate monitors and ultrasound gel (PT Department)  
|           |                |                            |                    |                           | • Nitro spray (PT Department – Nancy will bring)  |
| #3        | Station 4 – Cole (COPD) | FC – Dana  
|           |                |                            | SP – Francis        |                           | • Small table  
|           |                |                            |                    |                           | • 2 chairs (not on wheels)  
<p>|           |                |                            |                    |                           | • Bedside table with tissues  |</p>
<table>
<thead>
<tr>
<th>CLSF ROOM</th>
<th>Station number</th>
<th>Scenario Name</th>
<th>Faculty Coach (FC)</th>
<th>Standardized Patient (SP)</th>
<th>CLSF Equipment and Room Set up</th>
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<td>Black font: CSAWG responsible</td>
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<tr>
<td>#2</td>
<td>Station 5 – Ducharme (Bronchiectasis)</td>
<td>FC – Halyna</td>
<td>SP – Anne</td>
<td>● Plinth with 1 pillow and sheet</td>
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<td></td>
<td></td>
<td></td>
<td>● Two chairs – one wheeled and one not on wheels</td>
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<td>● Bedside table with paper and pens</td>
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<tr>
<td>#1</td>
<td>Station 6 – Sommers (Pediatric bronchiectasis)</td>
<td>FC - Melanie</td>
<td>SP – Natalie</td>
<td>● Plinth</td>
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<td></td>
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<td></td>
<td></td>
<td>● Towels (5 per day)</td>
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<td></td>
<td></td>
<td>● 2 boxes of tissues</td>
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<td></td>
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<td>● 2 chairs – 1 with wheels and 1 without</td>
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<td>● Soft/plush doll to demonstrate on (PT Department)</td>
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<td>● Palm cup (PT Dept.) and mechanical percussor</td>
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<td>● Drainage education sheets yellow (PT Department, will bring)</td>
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<tr>
<td>Area for Timer</td>
<td>SC –Nancy G</td>
<td></td>
<td></td>
<td>● Small table and chair with microphone</td>
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<td>● Timer script (PT Department, Liz will bring)</td>
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<td>● Student rotation schedule (PT Department, Liz will bring)</td>
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<td></td>
<td>Bob Christle, Karen Tusa</td>
<td></td>
<td></td>
<td>● 12 clipboards, paper &amp; pencils) (PT Department)</td>
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<td></td>
<td>S6 / OSCE overseer: Liz</td>
<td></td>
<td></td>
<td>● Black cart on wheels (PT Department)</td>
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<td></td>
<td>Back up FCs: Wednesday TBA Thursday</td>
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<td>Back up SPs: (leave at 9:30 am if not needed)</td>
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