# Annual Mentor Training Workshop

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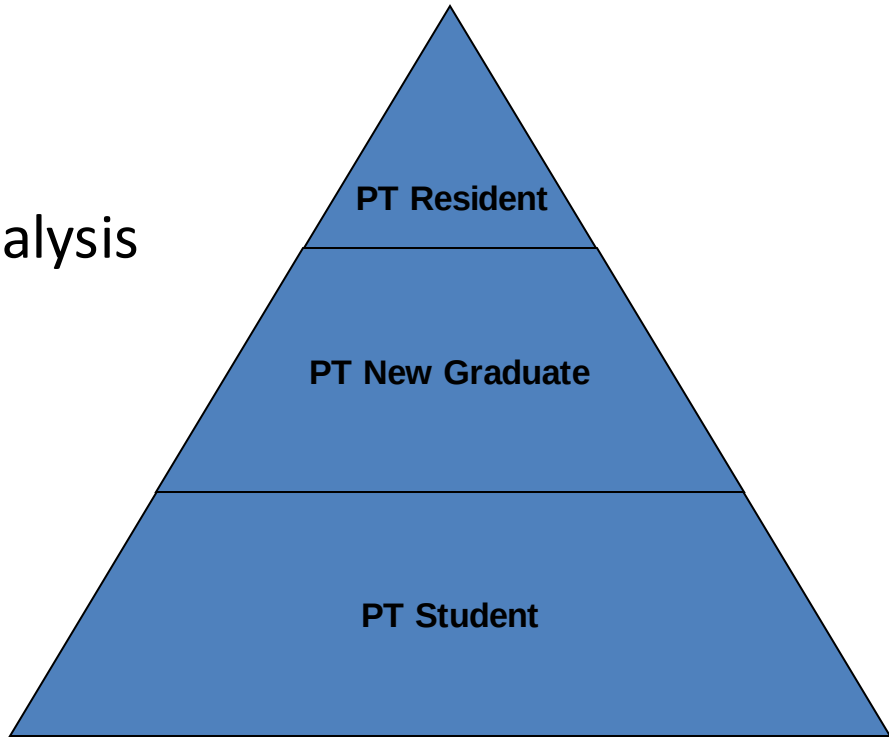
# Objectives

- Describe the differences between mentoring a student and a Resident
- Review the structure of mentored time
- Describe the ICF Model and its utilization through the Mentor Prep Form
- Review the 5 Microskills of Clinical Teaching

# PT Student vs. Resident

Continuum of Professional Development




Resident:

- Extended mentoring
- Expanded problem solving and analysis

PT Student:

- Shorter duration of mentoring
- Basic PT management skills
- Skill Acquistion
- Safety

# PT Student vs. Resident

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## PT Student

- May not appreciate the context of clinical data
- Less communication with MD and other team members
- Need to prepare to examine and treat a broad range of clinical presentations
- Clinical Instructor as a:
  - Instructor/guide
  - Facilitator

## PT Resident

- More time for interdisciplinary communication and referral
- Better able to address the interactional challenges of patient management
- More focused caseload within specialty area
- Clinical Instructor as a:
  - Facilitator
  - Mentor
  - Colleague

# PT Student vs. Resident

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## PT Student

- Limited practical clinical knowledge; more rule governed
- Tends to focus on basic level:
  - Interview skills
  - Patient service
  - Tests and measures
  - Interventions
  - HEP instruction

## PT Resident

- Initially more rote, but able to move to more focused interview and exam
- Able to develop multi-faceted management plan with greater emphasis on treatment selection and progression

# Mentored Time

- Consistent evidence-based mentorship is one of the key components of Kessler's Residency
- Resident requires a minimum of 150 hours of mentored time throughout residency year
- Typical week needs to include a minimum of 3 hours of mentorship
  - Average of 3 hours/week for 50 weeks/year
  - Several weeks will require greater mentored hours to account for PTO and SDO time

# Mentored Time

- A minimum of 100 (of the 150) hours of mentored time needs to be billable time involved in direct patient care with the Resident billing for the session
- 50 (of the 150) hours can be time billed by the mentor for mentored sessions, or time spent in preparing for or debriefing following the mentorship session to reflect and discuss further needs related to this diagnostic category, patient, or intervention

# Mentored Time

- Mentorship sessions can be driven by:
  - Resident: Seeking to apply knowledge learned in didactic coursework, develop problem solving with a specific diagnostic category, determine a more effective approach to achieve an outcomes with a patient
  - Mentor: Possesses a level of expertise in a specific intervention or program, determines a need for growth in an identified area, seeking to establish carryover from areas of previous training and mentorship

# Mentored Time

- Focused mentorship should occur in areas addressed in the Neurologic DSP, including addressing a wide ranges of diagnoses, varied outcome measures, and interventions
- Can relate to:
  - Special Programs (Wheelchair Seating, Brace Clinic)
  - Outcome measures (Research and incorporation of most appropriate measure to assess dynamic balance)
  - Treatment Interventions (Gait training for the ataxic patient)
  - Synthesis of information (Method of instructing positioning for spasticity management to the client with receptive aphasia)

# Mentored Time

- All mentored sessions should be based in evidence and incorporate critical inquiry
- The Resident will drive this aspect of mentorship. However, the mentor is responsible for understanding of the information and concepts incorporated. This will be structured through:
  - Reviewing articles or resources provided by the Resident related to the session
  - Reviewing Mentor Preparation Forms
  - Understanding the ICF Model
  - Incorporating the 5 Microskills of Clinical Teaching

# Mentored Time

- Resident can self-determine an area of needed mentorship due to interest on the topic, need for improvement, concern with roadblock in sessions, information from evidence-based research
- Mentor can identify and direct the Resident in a proposed mentorship topic based on skill set, areas for growth, patient specific cases, information from evidence-based research
- Incorporate information from didactic coursework, educational sessions, in-services, or specialty clinic observations

# Mentored Time

- Knowledge of the didactic coursework and timely incorporation of the material is a core element of the Program to demonstrate clinical application of webinar and on-site course knowledge:
  - Determine a patient requiring specific gait analysis for orthotic prescription within first 2 weeks of August (course)
  - Identify patient with pharmacological impacts/concerns last week of August (webinar)
  - Seek out vestibular screening or evaluation at end of September (webinar)
  - Identify a patient with cerebellar dysfunction in mid-November (course)

# Mentored Time

- Mentored time each week can be structured in varied ways
  - One patient for a consecutive 3 hour session
  - One patient for 2 different sessions in that week totaling 3 hours
  - Multiple patients over one day, or across several days (i.e. 2 patients with CVA seen for 90 minutes each on Tuesday and Thursday)
  - One patient over several relatively consecutive days (i.e. same patient for 1 hour on Monday, Wednesday, and Friday)
- Consider treatment model and potential for other issues such as cancellations when scheduling sessions

# Mentored Time

- Resident will be required to complete the Mentor Prep Form an average of 1 time per month and submit to mentor by the morning before the scheduled mentor session
- Mentor must review form and other supportive materials prior to mentored treatment session, and the key is to discuss the plan prior to the mentored session
- A Mentor Feedback Form must be completed for all mentored sessions. Will be initiated by the Resident, and the Mentor to complete their portion no later than the end of the week that the mentored session(s) are performed

# Mentored Time

- Make the work of long forms meaningful for Residents and Mentors
- Important to take the time to review and discuss all content
  - Review evidence, integrate ideas into session
  - Discuss medications
  - Talk about outcomes that may be completed beyond the session or episode of care (i.e. participation measures)
  - Discuss prognosis and future interventions
- Even when long forms not completed, take the time to discuss plan for the session and incorporate probing questions throughout

# Mentored Time

- Can provide 2 separate mentorship sessions based on the same Mentor Prep Form to add up to multiple hours of mentorship for that week
- Can carryover the same mentorship form or topic to another week or different patient
  - The expectation is the Resident complete an average of two long mentor forms per month
  - When a long form is not completed, the Resident and Mentor are still required to fill out a Mentor Feedback Form related to the session(s) to adequately reflect that mentored time was completed
- Can seek out updated or modified information if further mentorship is needed on a topic
  - I.E. Resident mentored in orthotic application for the CVA patient in week 4, requests mentorship regarding orthotic application for incomplete SCI in week 6, using new supportive literature

# Mentored Time

- Best practice is for reflection and debriefing to occur immediately following the session, or no later than 24 hours later, to assure Resident is clear on outcomes of the session. Debriefing and discussion may occur within the context of reviewing the medical record documentation related to the session
- Debrief/discuss the session
  - Even if the Resident makes the right choices, educate them in how to deconstruct it
  - Determine areas of strength and opportunities for further growth
  - Discuss future mentorship opportunities
  - Complete the Mentor Feedback Form

# Mentor Feedback Form

- Resident must submit to mentor within 48 hours of when the session occurred, or the end of the week should subsequent sessions on the same patient occur

- Mentor must complete as soon as possible but no later than within one week

# Mentor Feedback Form

- Assess Resident's Preparation for treatment sessions:
  - Ability to use ICF model to determine appropriate treatment plan
  - Development of appropriate goals
  - Comprehensive review of literature
- Resident's use of evidence based practice/objective measures:
  - Resident utilized literature review and other resources in order to develop treatment that was evidence based and/or used objective measures in the assessment

# Mentor Feedback Form

- Resident's Clinical Reasoning Skills
  - Resident's ability to interpret patient outcomes based on clinical data, client performance, professional judgement and knowledge
- Patient Outcome of treatment session:
  - Resident's ability to adapt treatment session based on patient response to therapy
  - Describe patient's outcomes from resident's interventions

# Mentor Feedback Form

- Resident's Area of Strength:
  - Describe Resident's strengths in relation to this mentoring session:
    - Example: Resident demonstrated excellent skills with assessing gait deviations and determining most appropriate bracing for patient
- Resident's Areas for improvement/further exposure
  - Areas for improvement in relation to this mentoring session or ways to further evolve skills based on this session
  - Example: The resident will benefit from improving handling skills and utilizing facilitation techniques during gait training of patient with an incomplete SCI

# Non-Mentored Time

- Resident treats an average of 24 hours/week non-mentored time
- Residents track every patient they treat using Weekly Patient Log to assure they are directly working with a range of neurological diagnoses
- The Resident should not be assigned to or responsible for coverage of patients with non-neurologic diagnoses or symptoms
- Exceptions:
  - History of neurologic diagnosis: Hip fracture with history of Parkinson's Disease
  - Proshetic training amputees: Prosthetic training and gait analysis is a component of the NCS and therefore appropriate to treat in limited quantity
  - Weekend treatment: The Resident can be assigned a mix caseload as other staff would be. However, ideally they would be on a floor/gym that sees at least a component of neuro patients. The Resident will only be allowed to track treatment of neuro patients on the log in this situation

# Non-Mentored Time

- Either Resident Mentors or other “Case Sharers” can be responsible for oversight of the Resident during non-mentored time
- These individuals are responsible for answering questions as needed, sharing treatment ideas, reviewing treatment plans in a new diagnostic category as appropriate, and assisting in documentation as the Resident is learning a new system

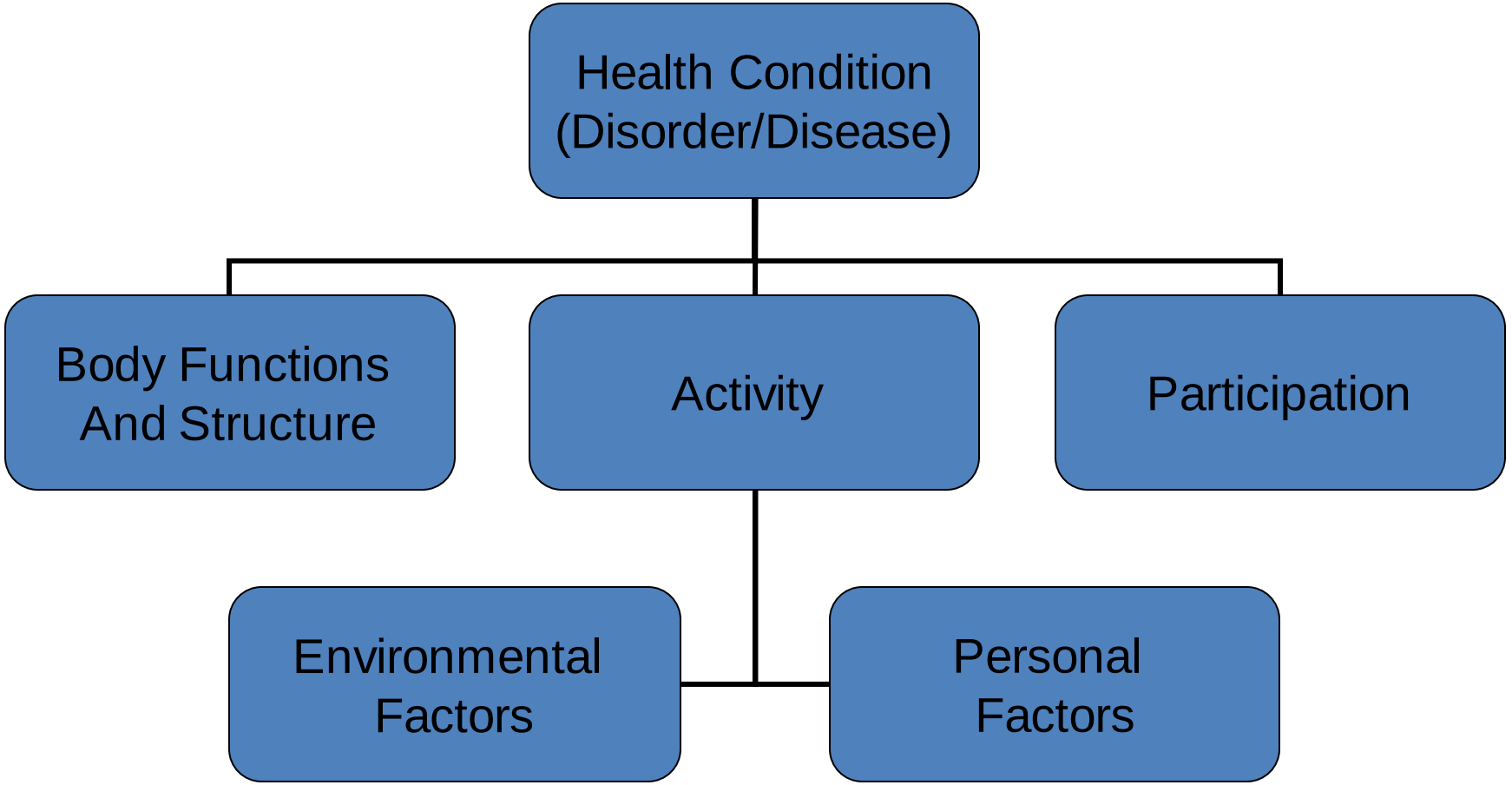
# Other Staff and Mentor Responsibilities

- Case Sharing
  - Offer treatment ideas
  - Review documentation
- Schedule oversight
  - Assure varied diagnoses being treated by the resident
  - Assist in patient and caseload swaps
  - Coordinate floor or gym shift when appropriate patient is admitted to a different area (i.e. patient with CP and hip fracture on first floor, resident typically treats on second floor)

# Other Staff and Mentor Responsibilities

- Specialty observations
  - Wheelchair Seating Clinic
  - Spasticity Clinic
  - RTI Program
  - Brace Clinic
  - Can be provided by PT, OT, ST, TR, Physician, Nurse, Psychologist, etc. to enhance the Resident's overall learning and understanding of treatment of the neurological patient
- Assist with in-service preparation or review
  - Complete Project Feedback Form
- Participate in research project

# ICF Model


Health Condition
(Disorder/Disease)
Body Functions
And Structure
Activity
Participation
Environmental
Factors
Personal
Factors

# ICF Model: Body Functions

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- Impairments of:
  - Mental functions
  - Sensory functions
  - Functions of the cardiovascular and respiratory systems
  - Neuromusculoskeletal and movement related functions
    - Mobility of joint, muscle power, muscle tone, involuntary movements

# ICF Model: Body Structures

- Impairments of:
  - Structure of the nervous system
  - Structure of the cardiovascular and respiratory system
  - Skin and related structures
  - Structure related to movement
    - Head and neck, shoulder, UE, pelvis, LE, trunk

# ICF: Body Structures and Function

- Both use qualifiers to describe extent
  - No impairment
  - Mild impairment
  - Moderate impairment
  - Severe impairment
  - Complete impairment
  - Not specified
  - Not applicable

# ICF: Activity Limitations and Participation Restrictions

- Learning and applying knowledge
- General tasks and demands
- Communication
- Mobility
- Self care
- Domestic life
- Interpersonal interactions and relationships
- Major life areas
- Community social and civic life

## ICF: Activity Limitations and Participation Restrictions

- Performance qualifier
  - Extent of participation restriction by describing actual performance of task in current environment
  - I.E. doing things they want to do
- Capacity qualifier
  - Extent of activity limitation by personal ability to do task or action without assistance

# ICF: Environmental Factors

- Products and technology
- Natural environment and human made changes (climate, light, sound)
  - Can a client with MS afford an air conditioner
- Support and relationships
- Attitudes
- Services, systems, and policies
  - Meals on Wheels
- Described in barriers or facilitators

# ICF: Personal Factors

- Lifestyle
- Habits
- Social background
- Education
- Life events
- Race/ethnicity
- Sexual orientation

# Development of Experts

- Meaningful patterns of information
  - Provide novices with learning experiences that enhance the ability to link what they know to meaningful patterns
- Organization of knowledge
  - Build conceptual understanding as a critical element in curriculum design
- Fluent retrieval
  - Instruction and testing should also focus on fully understanding the problem and the situation, not simply on accuracy
- The mentor needs to decide if the way a resident came to a conclusion is appropriate and reflects the understanding of a higher level of expertise. If it is not, the mentor determines if it is because the individual got there the *wrong* way, or if they got there a *different* way

# Common Pitfalls in Mentoring to Develop Clinical Reasoning

- Instruction is focused at specific areas within the framework- avoid producing an individual narrow in assessment
  - Consider how gait will differ not just in clinic but on the beach, climbing stadium stairs
- Contextual factors can be blown over to deal with the more immediate issues at hand (techniques)
  - If resident is someone does well in administering the Berg Balance Scale, can he/she understand how it applies to a patient with hip fracture and Parkinson's Disease
- The mentor gives the resident clinical reasoning without getting the resident to struggle and problem solve themselves
  - Wait for an answer
  - Deal with the silence

# Five Microskills for Clinical Teaching

- Most clinical teaching takes place in the context of active clinical practice
- Microskills enable teachers to effectively assess, instruct, and give feedback more efficiently
- This model is used when the teacher knows something about the case that the learner needs or wants to know
- Clinical teachers play different professional roles: Expert consultant, joint problem solver, Socratic teacher, and, when appropriate, the One Minute Preceptor

# 1) Get a Commitment

- Cue: Learner presents the facts, then either stops to wait for a response or asks guidance in how to proceed. Learner does not offer an opinion on the data presented. The immediate response is often to tell the learner the answer
- Preceptor: Instead, ask the learner to state what he/she thinks about the issue presented by the data. Issues may include coming up with more data, proposing a hypothesis, figuring out why the patient is non-compliant, deciding who to consult
- Rationale: Asking a learner how they interpret data is the first step in diagnosing learning needs. Without knowing the learner's knowledge, teaching may be misdirected and unhelpful. When encouraged to offer suggestions, learners feel responsibility for patient care and enjoy a collaborative role in problem resolution

# 1) Get a Commitment

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Examples

- What do ***you*** think is going on with this patient?
- What other types of information do ***you*** feel are needed?
- What would ***you*** like to accomplish in this visit?
- Why do ***you*** think the patient has been non-compliant?

Non-examples

- This does not involve offering your own opinion:
  - "This is obviously a classic presentation of autonomic dysreflexia."
- This is not asking for more data or Socratically leading the learner to the right answer:
  - "You missed 2 out of 3 key symptoms. What are they?"
  - "Do you think the lack of family support is the reason for non-compliance?"

# 2) Probe for Supporting Evidence

- Cue: In discussion, the learner has committed themselves on the problem and looks to mentor to confirm an opinion or suggest an alternative. Mentor may or may not agree with the opinion, and instinct is to tell them thoughts on the case outright
- Preceptor: Before offering opinion, ask the learner for evidence he/she feels support his/her opinion. Another approach is asking what other choices were considered and what evidence supported/refuted those alternatives
- Rationale: Learners proceed with problem-solving logically from their own data base. Asking them to reveal thought processes allows you both to identify where there are gaps. Without this information, you may assume they know more or less than they do, and risk targetting instruction inefficiently

# 2) Probe for Supporting Evidence

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Examples

- What were the major findings that lead to your conclusion?
- What else did you consider?
- What are the key features on this case?
- What questions are arising in your mind?

Non-examples

- It is not list-making or oral-examination
  - "What are the possible causes of CHF?"
- It is not a judgment on learner thinking
  - "I don't think this is a bacterical infection. Don't you have other ideas?"
- It is not your own opinion on the case
  - "This seems like a classic case of tendonitis."
- It is not asking for more data on the case than was presented initially
  - "You didn't talk about the patients major contraindications and how his past medical history will impact function so tell me that now.

# 3) Teach General Rules

- Cue: You have ascertained from what the learner revealed that the case has teaching value, i.e. you know something about it which the learner needs or wants to know
- Preceptor: Provide general rules, concepts or considerations, and target to the learner's understanding.
- Rationale: Instruction is more memorable and transferrable if it is offered as a general rule or guiding metaphor. Learners value approaches stated as more standardized for a class of problems or as key features for a particular diagnosis.

# 3) Teach General Rules

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Examples

- Phrase a generalizable teaching point as "When this happens, do this…"
- "When a patient with SCI demonstrates emergence of a movement, it is important to reassess the AIS level."
- "Patients with cystitis usually experience pain and increased frequency with urination. The urinalysis should show bacteria and white blood cells."

Non-examples

- It is not the answer to a problem (though this may also be needed) but rather approach to solving it
  - "This patient has balance issues so just do the Berg."
- It is not an unsupported, idiosyncratic approach
  - "I think stretches held for 10 minutes are more beneficial than those held for 5 minutes."

# 4) Reinforce What is Right

- Cue: The learner has handled the situation in an effective manner resulting in helping you, patients, or colleagues. The learner may or may not realize the action was effective and had such an impact
- Preceptor: Take the first chance you find to comment on 1) the specific good work and 2) the effect it had
- Rationale: Good actions may be deliberate or by chance. In either case, skills in learners are not well-established and therefore vulnerable. Unless reinforced, competencies may never be firmly established.

# 4) Reinforce What is Right

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Examples

- "You didn't jump into solving the patient's presenting problem but instead kept open until she revealed her agenda for the visit. You saved yourself and the patient a lot of time and unnecessary expense by getting to the core of her concerns first."
- Obviously you considered the patient's finances in your selection of a therapy schedule. Your sensitivity to this will certainly contribute to improving his compliance."

Non-examples

- It is not general praise
  - "You are absolutely right. That is a wise decision."
  - "You did that initial evaluation well"

# 5) Correct Mistakes

- Cue: The learner's work has demonstrated mistakes that will have an impact on patient care, team functioning, or learner effectiveness
- Preceptor: As soon after the mistake as possible, find a time and place to discuss what was wrong and how to avoid or correct the error in the future. Allow the learner to self-critique performance first.
- Rationale: Mistakes left unattended may be repeated. Discussing mistakes first allows the mentor to assess both learner knowledge and standards.

# 5) Correct Mistakes

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Learner awareness of mistakes is important

- Learners who are aware of their mistakes and know what to do differently in the future need only to be reinforced
- Learners who are aware of mistakes but unsure of how to avoid the situation in the future can benefit from a “teachable moment” (appreciate tips that will help them avoid uncomfortable situations in the future)
- Learners who are unaware they made a mistake or are unwilling to admit the error are troublesome. In order to maximize learning for them, detailing both the negative effect as well as the correction are both essential for effective feedback

# 5) Correct Mistakes

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Examples

- "You may be right that the patient's loss of ROM is due to hetertrophic ossification. However you cannot be sure until it is confirmed with X-ray or MRI."

Non-examples

- Avoid vague, judgmental statements:
  - "You did what?"
  - "Your approach did not make any sense, and that is why the patient did not improve"

# References


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# Questions?

*Thank You!*