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Abstract

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Keywords

Peer assisted learning, peer mentoring, learning dyads

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A Dyad Model of Peer-Assisted Learning in an Occupational Therapy Student Experiential Learning Clinic for Hand Therapy

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ABSTRACT

Peer-assisted learning (PAL) in healthcare education encourages critical thinking, professional development, knowledge acquisition, and enhancement of clinical skills. In this paper, we describe the pilot of a dyad model of PAL used in an occupational therapy (OT) student experiential learning clinic for hand therapy, where two students at the same knowledge level provided peer support to one another in clinical responsibilities. Example activities where dyad learning occurred include evaluation and treatment planning, care delivery, documentation, presenting during clinic rounds, practicing administering assessments and treatment techniques, and role-playing sensitive patient conversations. We developed two supplemental tools to support feedback between peers: the Session Rating Tool for post-treatment feedback and the Documentation Checklists for evaluating documentation. We assessed the effectiveness of the dyad model and the two tools by first exploring students' anticipated impact on a total of nine criteria essential to professional growth and hand therapy clinical practice, which was rated on a Likert Scale. After a six-week pilot period, the same questions investigated students' perception of actual impact. Students also provided qualitative feedback via open text on each survey. Students rated the dyad learning model highest for overall confidence in clinical skills/treating patients and rated the model's impact higher than anticipated on clinical reasoning skills, therapeutic use of self and other communication skills, upper extremity diagnoses and conditions, and OT process. Students rated the Session Rating Tool similarly to anticipated impact. The dyad model of PAL supported student learning and clinical performance in this student experiential learning clinic.

Introduction

Peer-assisted learning (PAL) is a collaborative learning strategy in which students help each other learn (Guraya & Abdalla, 2020; Henning et al., 2008). Peer-assisted learning occurs both informally and formally in structured curriculum and clinical environments (Henning et al., 2008). Peer-assisted learning includes variations of peer teaching, peer assessment, peer mentoring, and peer leadership (Guraya & Abdalla, 2020; Henning et al., 2008). Peer-assisted learning can occur as direct peer learning, when students belong to the same class, or near-peer mentoring, when students are paired with more experienced students (Guraya & Abdalla, 2020). Benefits of PAL are bidirectional, as students are more engaged through a collaborative learning effort which reduces stress and prompts ownership of one's learning (Zhang & Maconochie, 2022). In higher education of health professionals, use of PAL in clinical settings encourages critical thinking, professional development, knowledge acquisition, and enhancement of clinical skills (Carr et al., 2016; Guraya & Abdalla, 2020). Peer-assisted learning is also emerging in student clinics (SCs; Seifert et al., 2016). In SCs the integration of PAL strategies increases students' knowledge, practical skills, confidence during patient encounters, and satisfaction of mentorship experiences (Choudhury et al., 2014; Seifert, 2016).

Dyads of students working together is a common form of PAL. In a dyad learning environment, students discuss patient encounters, diagnoses and conditions, treatment plans, and shared learning goals (Tolsgaard et al., 2013). A variety of collaborative learning methods occur within dyad learning including information sharing, seeking feedback with peer when making clinical decisions, and shared processing of intervention outcomes (Austria et al., 2013). Benefits of dyad learning by students include reduced anxiety in clinical encounters (Räder et al., 2014; Tolsgaard et al., 2013), increased confidence and task efficiency (Tolsgaard et al., 2013), improved self-efficacy through social interactions with peers (Räder et al., 2014), useful insight through observation (Räder et al., 2014; Wulf et al., 2010), and enhanced motivation (Räder et al., 2014; Wulf et al., 2010). From a logistical perspective, dyad learning is a cost-efficient student training method. Two students can practice at the same time and use the same resources that would typically be required for only one student using traditional, individual practice without jeopardizing the quality of student learning or patient outcomes (Wulf et al., 2010). In fact, studies demonstrate dyad learning is more effective and efficient than individual practice in clinical settings and is often well-received by students (Räder et al., 2014; Tolsgaard et al., 2013; Wulf et al., 2010). The main concern regarding dyad learning is decreased hands-on training for practical skills (Tolsgaard et al., 2014).

In this paper, we describe the formation of a dyad peer mentorship model used with occupational therapy (OT) students within a student clinic setting and present initial outcome data following the pilot period.

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Description

The Student Experiential Learning Clinic for Hand Therapy

In response to a call for uninsured patients with hand and upper extremity conditions to have access to OT, an OT program at a Midwestern university with an affiliated teaching hospital formed a Student Experiential Learning Clinic focusing on hand therapy (SELC-HT). Students seeking an entry-level master's or doctorate degree complete a series of courses in a matched faculty mentor's research or clinical laboratory, such as the SELC-HT. Initially the SELC-HT used a near-peer mentorship model, with second-year students providing patient care with mentorship of a third-year student and supervision of faculty and clinician. After several years of operation, a curriculum revision removed the third-year students, requiring a shift to direct-peer learning between a dyad of second-year students. This project describes the process, design, and evaluation of the move to this new peer-assisted learning method with four students who participated in the first cohort in this revised experience.

Students worked in dyads to collaboratively plan and perform the initial evaluation, select models of care and design treatment plans, and deliver care. One student in each dyad assumed the primary student therapist role and the other student observed, coached, and provided feedback. Students split the patient load to ensure equal opportunity to assume therapist and observer roles. The primary student therapist performed all patient evaluations, delivered direct patient care, completed all documentation forms, and reported during clinic rounds. The student observer attended each patient encounter, assisted the primary student therapist as needed, and reviewed all documentation forms. The student dyads met virtually or in-person for detailed feedback and in-depth discussion of documentation, professional behaviors, and clinical skill development. The student observer also served as a back-up if the student therapist was unable to attend due to illness, which was needed due to the ongoing COVID-19 pandemic.

To address Tolgaard and colleagues' (2014) concern regarding practical skill training, the student dyads practiced administering assessments, hands-on manual techniques, and role-playing sensitive patient conversations with each other. In the new dyad PAL model, students continued to use the original treatment planning and documentation tools developed in the SELC-HT, and the faculty member and/or clinician supervisor continued to observe all patient care sessions, approve all planning and documentation generated, and hold weekly patient rounds with students as before. We elected to maintain the same dyad groups throughout the entire semester.

Supplemental Tools for Dyad Peer-Assisted Learning

Since the third-year mentors were no longer available to provide near-peer mentorship, it was apparent we needed to develop methods to ensure the success of the student dyads. In a narrative systematic review, several included studies introduced a tool, form, or other explicit framework, for students to use when engaging in direct peer learning in a clinical setting, such as providing constructive feedback to one another (Tai et al., 2016). Support tools also provide transparency to learners by providing criteria on which

they will be evaluated, with a "post-encounter form" sourced from the Reporter-Interpreter-Manager-Educator (RIME) framework as an example (Tolsgaard et al., 2013). We synthesized multiple sources from peer-reviewed literature and materials developed by and routinely used in the SELC-HT, including documentation templates and clinical reasoning modules, to develop two supplemental tools. Official materials from the American Occupational Therapy Association (AOTA) already in use in the SELC-HT also informed these supplemental tools, including the Fieldwork Performance Evaluation (AOTA, 2002) and the Occupational Therapy Practice Framework, 4th edition (AOTA, 2020). We also referenced the series of seven training modules previously developed for the SELC-HT when creating these tools.

The first tool, the Session Rating Tool, was completed by the observing student to provide post-treatment feedback to promote development of clinical skills and reasoning. The Session Rating Tool includes eight criteria: Adheres to OT code of ethics and safety regulations, communicates role/value of OT & occupation, establishes and maintains rapport with client, observation skills, clinical reasoning skills, use of skill-based assessments and interventions, collaborates with client, and respect for diversity. The observing student rated the treating student therapist as "effective" or "needs improvement" based upon the "effective" operational definition described for each criterion (see Appendix A).

The second tool was a group of Documentation Checklists, which are templates students used to compare their partner's evaluation and treatment planning documents and evaluation and treatment session notes to pre-established criteria. The Documentation Checklists drew from established planning and documentation templates used in the SELC-HT, which follow the SOAP documentation format commonly used in healthcare. The observing student rated each criterion as "agree" or "discuss" and initiated a documentation discussion to facilitate constructive feedback and learning. A total of four Documentation Checklists were developed: 1) initial evaluation planning worksheet, 2) initial evaluation report, 3) treatment plan, and 4) treatment note. Appendix B details the four Documentation Checklists. Students in the SELC-HT, the clinician supervisor, and the faculty mentor reviewed these two supplemental tools, and we modified them as suggested before piloting with students to be used during patient care.

Program Outcomes of Pilot Period

The faculty mentor with experience in survey research and one of the participating students developed a survey to measure students' ratings of the dyad PAL model and supplemental tools developed on a 5-point Likert scale (1=no impact to 5=great impact). Specific areas are described in Table 1. Open-ended questions captured specific feedback and suggestions. The survey was sent through Qualtrics software (Qualtrics, Provo, UT). The university Institutional Review Board determined this project as exempt due to program assessment.

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After completing six weeks of clinic activities using the supplemental tools in the dyads, students completed a follow-up survey similar to the pre-pilot survey to measure the perceived impact of the dyad peer mentorship model and the supplemental tools. All four second-year students in the SELC-HT responded to both surveys. Refer to Table 1 for detailed ratings of the dyad model and both tools on each construct.

Table 1

Anticipated Impact (Pre) and Perceived Impact (Post) Ratings of Dyad PAL Model and Two Supplemental Tools (n=4)

	Dyad PAL Model		**Session Rating Tool**		**Documentation Checklist**	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**
Overall confidence in clinical skills/treating patients in the SELC-HT	5.00	5.00	4.75	4.75	4.00	3.5
Clinical reasoning skills	4.25	4.75	4.5	4.5	4.00	3.5
Therapeutic use of self and other communication skills	4.50	4.75	4.75	4.75	*	*
Upper Extremity Diagnoses and Conditions	4.00	4.25	3.25	3.50	*	*
Researching evidence-based practices	3.25	3.75	*	*	3.25	3.25
Ability to address OT Domain and perform OT Process	*	*	4.25	4.25	4.00	3.5
OT Domain	4.25	4.25	*	*	*	*
OT Process	4.25	4.75	*	*	*	*
Documentation skills	4.75	4.75	*	*	*	*
Developing the “A Section” of evaluation and intervention notes	*	*	*	*	4.25	4.25
Goal Setting	*	*	*	*	4.00	3.75

Note. 5-point Likert scale (1 = no impact, 5 = great impact).
*Category not measured for corresponding model and/tool

The students perceived the dyad model would be beneficial to their learning in all constructs prior to the pilot period, with one student predicting “these tools will be incredibly beneficial to my ability to provide constructive feedback as well as think critically about my own skills.” After the pilot period, students rated the greatest impact of the dyad learning model on overall confidence in clinical skills/treating patients in the SELC-HT, with all four students rating at the highest level (5). In the open-ended question, one student noted “the dyad system really promotes growth and clinical reasoning.” Students rated the dyad learning model lowest post pilot period for researching evidence-based practices; however, this rating was higher than the anticipated impact. Several other post-pilot perceived impact ratings that increased from the pre-pilot anticipated ratings included clinical reasoning skills, therapeutic use of self and other communication skills, upper extremity diagnoses and conditions, and OT process. Students rated the Session Rating Tool most impactful in constructs related to direct interactions with patients, like therapeutic use of self and communication skills and confidence in clinical skills.

Students rated the Documentation Checklists less in most areas than the dyad model and the Session Rating Tool but found the Documentation Checklists most impactful for ability to write the assessment section of the SOAP report/note. Interestingly, students anticipated the impact of the Documentation Checklists higher than they perceived them to be in four areas following the pilot period.

Data from the open-ended question indicated that students found the Session Rating Tool most beneficial for giving and receiving feedback, along with tracking their own progress of OT knowledge and skills. One student stated, “I enjoy the Session Rating Tool because a lot of my goals are related to feedback. I feel this is a great way to prepare students for fieldwork.” Furthermore, a student reported, “I absolutely love the Session Rating Tool. I have been able to track my progress as well as buff up my own clinical reasoning when reviewing my peer.” Students found the Documentation Checklists most useful for the student-therapist’s assessment section, or “A” section, of a treatment note. One student noted, “I found myself really only using [the Documentation Checklists] to guide my “A” section. The “A” section is the trickiest, so I think having a guide is a great way to help focus my assessment, but I don’t think it’s as necessary for the rest of the documentation sections.”

Discussion

When our OT program underwent a curriculum revision, the SELC-HT needed to identify and implement a new PAL model. The SELC-HT’s use of direct-peer mentorship via student dyads to manage patient cases proved to be effective. Although the students perceived the dyad model would be beneficial to their learning in all constructs prior to the pilot period, we found they rated the model higher in five out of the eight constructs at the conclusion. Dyad PAL is supported in the literature where participating students felt “more confident about performing clinical tasks and applying skills learnt in a real-work environment” (Chan et al., 2021, p. 2). This statement was echoed in the select open-ended responses from students when they reported that the dyad PAL model had the highest impact on their confidence in their clinical skills and treating

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patients in the SELC-HT. Students also reported a greater understanding of upper extremity diagnoses and conditions and development of clinical reasoning skills through the dyad learning PAL model. This improvement in knowledge and skills may be due to cognitive and social factors unique to dyad learning where shared memory and similar knowledge framework between students reduces individual cognitive load (Tolsgaard et al., 2014) and enhances overall knowledge and skill acquisition (Jawhari et al., 2021; Seifert et al., 2016). We did not find that the decreased hands-on training time negatively impacted students' perception of their professional growth, a concern in previous studies (Tolsgaard et al., 2014), perhaps due to the specific skills students practiced in the dyads, outside of patient care time.

We found that the formal mechanisms put in place to help students serve as direct-peer mentors were essential, specifically the Session Rating Tool and Documentation Checklists. These supplemental tools supported the inexperienced students by giving them tangible criteria for high quality patient care and for providing feedback to each other. Our results indicate the Session Rating Tool impacted students' therapeutic use of self and confidence in treating patients. On the other hand, the Documentation Checklists demonstrated the greatest impact related to the development of students' documentation skills, as expected. The Session Rating Tool was rated high pre-pilot in four out of five constructs, and students rated these constructs the same post-pilot, with the lowest rated item, "research evidence-based practices," increasing.

Interestingly, we found that the students rated the Documentation Checklists less impactful post-pilot period in four constructs as evidenced by the decreased scores at the end of the pilot period. As one student noted, the documentation checklists were only useful to them for a particular part of the note (Assessment). As students worked with clients throughout the pilot period, their documentation skills ostensibly improved. They may have felt that having four Documentation Checklists became cumbersome after a while. The students may have stopped using the Documentation Checklists as intended by picking only the areas they felt they needed continued support throughout the pilot period, while they continued to use the Session Rating Tool as intended. A future study could consider streamlining the Documentation Checklists to address the specific parts of necessary documentation where students need continued assistance. It might be useful to start with the full Documentation Checklist and begin to taper off usage as students grow more accustomed to proper documentation. Nevertheless, the two supplemental tools addressed different constructs important to high value patient care: care delivery skills and documentation skills. The combination of using these tools within a dyad learning PAL format complimented the experiential learning for students in the SELC-HT.

Limitations and Future Directions

Our student cohort was small, limiting the generalizability of our findings. Our OT program emphasizes peer feedback, thus, students in this study may be more accustomed to these interactions and needed less faculty support than students in other OT programs or other student clinics. A few of the criteria listed in our outcomes are specific to OT and are not applicable to student clinics outside the discipline.

Future work should investigate the impact of the dyad learning model and supplemental tools on specific OT skills within student clinic settings as well as in general OT curricula where it could be applicable. Faculty or students themselves could evaluate growth and progress by analyzing the ability to integrate feedback from the supplemental tools throughout the semester. Additional studies in other disciplines could also support the dyad learning PAL model and the use of supplemental tools throughout healthcare education.

Implications for Occupational Therapy Education

We believe OT educators can incorporate findings from this study through the following suggestions:

- Experiential learning in an OT student clinic can go beyond direct patient care and include professional interactions such as providing constructive feedback.
- Students at same level of development can provide meaningful support to each other and a dyad model of PAL should be considered in OT student clinics or other opportunities where students provide care for clients.
- Designing supplemental tools for evaluation that mimic criteria from AOTA's Level II fieldwork performance evaluation allows students to learn and practice skills during didactic coursework needed on fieldwork and beyond.
- The dyad model and supplemental tools may be useful during clinical experiences, including level I and level II fieldworks.
- Consider using supplemental tools for evaluating students in case-based learning, standardized patient encounters, or assignments related to documentation.
- Include students in planning and evaluating peer learning activities and tools to assure they are meaningful and useful to professional growth.
- Collect data from multiple timepoints using feedback forms to track professional growth.

Conclusion

Peer-assisted learning occurs in student clinics and has many documented benefits. The dyad model is a form of PAL, and in our student clinic, students used this model to collaborate in many ways including preparing for evaluation, designing treatment plans, and choosing theories to guide patient care. In the SELC-HT, the dyad model and the two supplemental tools resulted in a successful learning experience for the students and gathering student input throughout the PAL design process strengthened the feasibility of the dyad model and usability of the tools. Use of the dyad model of PAL in student clinics and other patient encounter learning experiences can prepare students for fieldwork experiences and future OT clinical practice.

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Appendix A

Session Rating Tool

Adheres to OT Code of Ethics & safety regulations Consistently adheres to OT Code of Ethics Anticipates potentially hazardous situations & takes steps to prevent accidents
Communicates role/value of OT & occupation Articulates the values and role of the OT profession Articulates the value of occupation as a method and outcome of OT to clients
Establishes and maintains rapport with client Appropriate verbal & non-verbal communication Lack of jargon Mode-matching Creating therapeutic alliance
Observation skills Closely observe client status to identify client factors, promote safety and identify levels of activity tolerance
Clinical reasoning skills Uses mix of intervention types: occupation/activity, support of occupations and education Modifies task approach, occupations, & the environment to maximize client performance
Use of skill-based assessments and interventions Administers assessments in a uniform manner to ensure findings are valid and reliable Correct application of manual techniques
Collaborates with client Includes client throughout OT process Trains and educates client in easily understandable manner Selects relevant occupations to motivate patient and facilitate meeting goals
Respect for diversity Demonstrates respect for diversity (socio-cultural, socioeconomic, spiritual, lifestyle, etc.)
Notes

Appendix B

Documentation Checklists

Initial Evaluation Plan

	Agree	Discuss
Priority constructs are appropriate and inclusive		
Notes relevant construct considerations & questions		
Every priority construct accurately linked to appropriate assessment method		
Identifies broad range of safety considerations appropriate for client (diagnosis, premorbid conditions, medications, surgical precautions, testing adaptations)		
Logical flow for assessment administration		
Parameters are clear and replication is possible		
Relevant discussion topics		

Initial Evaluation Report

	Agree	Discuss
Reports relevant client statements that demonstrate occupational performance and participation issues		
Standardized assessment results clearly noted and compared to norms		
Qualitative results and relevant observations are described in understandable manner		
Assessment section applies findings from Objective section to identify factors limiting occupational performance, intervention priorities, and potential to achieve goals		
Short term goals support long term goal achievement and timeline is realistic		
Goals relate to patient's priorities and physician's referral, and optimization of occupational performance		

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Treatment Plan

	Agree	Discuss
Identifies main issue(s) interfering with client's occupational performance/ participation		
Logical explanation of frame of reference/intervention approaches		
Identifies meaningful and relevant client goals		
Logical connection between goal and intervention type		
Activities are clear and replication is possible		
Hypothesizes additional questions/further discussions		
Treatment session has a logical flow, optimizes client safety		
Relevant evidence to support treatment plan		
Clear reasoning behind home activity program		

Treatment Note

	Agree	Discuss
Reports relevant client statements that link to areas of concern		
Evaluation/re-evaluation data clearly reported and interpreted		
Treatment activities target goals and reflect intervention approaches/frame of references		
Reports client's response to treatment and details possible contributing factors		
Reports why activities were or were not tolerated well		
Intervention type percentages and Person-Environment-Occupation factors match treatment documented		
Assessment section applies findings from Subjective and Objective sections to clinically reason effect of treatment, progress to date, areas that continue to limit performance, and need for continued treatment		
Clear rationale for continuation/discontinuation of OT		
Clear rationale for client rehabilitation potential		
Goals updated and changes to plan of care summarized in Plan		