

Do physiotherapy students perceive that they are adequately prepared to enter clinical practice? An empirical study

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Objective. To determine the perceived level of preparedness for clinical practice of third-year physiotherapy students.

Design. A prospective, descriptive study, using questionnaires to determine subjective perceptions and clinical test marks for objective measures of performance, was undertaken. Two different cohorts were recruited of third-year students entering clinical practice for the first time.

Method. A 17-item questionnaire relating to areas of competence was developed. Results of questionnaire scores and test scores from the 2 cohorts were amalgamated and analysed. Participants were grouped according to their clinical placement. The internal consistency of the questionnaire was tested using Cronbach's alpha. As this was high at 0.847, the individual scores were added together and the mean score calculated. Analysis of variance (ANOVA) was used to establish if there was a significant difference in scores across different areas of competency and on test marks, across the different clinical settings.

Main outcomes measure. Means and 95% confidence intervals of the mean scores of each component of competence indicated a significant difference between the scores ($p < 0.001$). One-way ANOVA and *post hoc* analysis revealed that the students perceived themselves as better prepared in affect (generic skills) than for intervention and overall preparedness ($F(4, 264) = 4.8601, p < 0.001$). There were no significant differences between the competency mean scores ($F(4, 53) = 0.804, p = 0.528$), or in the mean test scores, across the placements ($F(4, 77) = 0.438, p = 0.781$).

Results. Most of the students perceived their level of preparedness as relatively high across all areas of competence, regardless of placement. Students also achieved satisfactory (>60%) test scores, indicating realistic estimations of their ability.

Conclusion. The sense of readiness confirms the alignment of the classroom curriculum and clinical expectations, which has largely come about through the positioning of permanent clinical educators as essential links between the classroom and the clinical setting.

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Practice within the clinical arena is recognised as the best means of socialising students into the physiotherapy profession^[1-5] and is known to make up an integral part of the undergraduate training of all health professionals.^[6]

Clinical training facilitates the transference of classroom-taught skills and knowledge into practice. In addition, it provides students with the opportunity to learn the behaviours and attitudes necessary for successful professional practice, and to develop negotiation, assertive, organisational and administrative skills while becoming aware of social contexts and resources, in order to be socially responsible.^[6]

Of concern is how the knowledge acquired by students in the classroom is transferred to, and applied within, clinical placements.^[4,7] In a situation where clinical educators work within the clinical arena and academics cover theoretical and practical content but spend less time supervising students in clinics, the expectations of clinicians and academics may differ widely, which may result in a disparity between the taught curriculum and the needs of the clinical placements, affecting the preparedness of students for competent clinical practice.^[8]

Consequently, some students may struggle to make the shift from the classroom to the clinical setting, and seem to lack the ability to transfer the skills they have been taught into patient management.^[3,4,9-11] The authors just cited propose that the difficulty may also be related to students' lack of generic skills and professional behaviour. Their research on the skills required by physiotherapy and medical students to achieve success in clinical practice emphasises the need to balance core skills and knowledge of basic sciences against generic competencies. These generic skills include communication, interpersonal skills, awareness of one's own attitudes,

a continued commitment to independent learning, the ability to adapt and change, and clinical reasoning.^[4,9,12,13] The need for change in clinical education models, to ensure reinforcement of both the specific and generic skills needed for professional clinical practice, has been highlighted.^[4]

An area that has not received adequate attention is the extent to which students perceive themselves to be prepared to enter clinical practice for the first time. There is little published research as to whether they themselves are aware of areas in which they might have received inadequate preparation.^[3,10] As there is a link between perceived competence in clinical skills and the ability to perform adequately with regard to patient management,^[14,15] the students' perception of their own ability may be an important predictor of actual performance.

The present article investigates physiotherapy students' perceptions of their own readiness as they shift from a classroom foundation to clinical reality. It also aims to explain some of these perceptions with reference to the unique positioning of clinical educators within the University of Cape Town (UCT)'s Division of Physiotherapy's framework. Traditionally, clinicians and academic staff have been responsible for the onsite clinical training of physiotherapy students. Rodger *et al.*^[16] looked at clinical training across a range of allied healthcare disciplines, including physiotherapy, noting how changes in staffing at clinical sites, increasing student numbers, and diversification of the clinical platform have affected the ability of clinicians to support clinical education initiatives. As a result, universities have increasingly had to rely on contracted outside personnel to assist clinical training.^[4] This approach, however, can be problematic. Such personnel often have very little paedagogical training, and input to students is varied

and inconsistent, leading to high dissatisfaction levels.^[17] This situation may be in contrast to permanent academic staff, who are increasingly being required to undergo training in educational skills.^[1]

Context

At UCT, physiotherapy is offered as a 4-year Bachelor of Science degree within the Department of Health and Rehabilitation Sciences. A challenge facing the Division of Physiotherapy is to prepare students for the significant changes in healthcare delivery within the South African context, as highlighted by Shear *et al.*^[18] The design of the undergraduate curriculum should balance the need to provide undergraduate students with a strong foundation in the basic sciences, appropriate physiotherapy-specific skills and techniques, as well as developing critical thinking and the necessary generic skills needed in clinical practice. Ultimately, the obligation of the physiotherapy curriculum is to prepare students for the workplace, which is practical, socially interactive and contextually varied.^[7,11]

The initial 2 years of the programme concentrate on the basic sciences and principles of physiotherapy. Clinical exposure starts in the second year, with weekly sessions of supervised group clinical work. From the third year of study, students work independently in a variety of clinical settings, rotating through general hospitals, paediatric sites, care of the elderly, neuromuscular skeletal (NMS) clinics and community areas. In their fourth and final year, students work increasingly fulltime in more complex clinical areas.

Students require numerous skills to manage their own patient load at the different clinical sites. The theoretical, technical and generic skills needed are similar to those previously discussed by several authors.^[4,9,13] For the purpose of this study, they have broadly been divided into:

- theoretical knowledge
- planning of an assessment and treatment
- execution of an intervention
- generic skills such as communication, time management, confidence and emotional readiness
- overall sense of readiness, i.e. the students' confidence that they are competent to practice at a third-year level.

At each site, students are supported by weekly clinical educator visits. These teaching sessions guide students in applying the above skills. Since 2009 at UCT, permanent clinical educators have been appointed to academic posts to support clinical education. In addition to being responsible for facilitating learning in clinical settings, the clinical educators participate on an equal footing with academic lecturers in all departmental activities, including curriculum planning. At the end of every clinical rotation of a 5-week block, each student's performance is evaluated by a clinical educator and a clinician. The evaluation takes the form of a practical exam on a patient and an overall block performance mark, together comprising a clinical mark for each student.

Objective

The aim of this study was to examine the extent to which 3rd-year physiotherapy students are adequately prepared for independent clinical practice. Both subjective and objective data were used. The study objectives, in 2 cohorts of 3rd-year physiotherapy students, were to:

- determine whether the majority of students felt adequately prepared for their first independent clinical block
- examine whether there was any difference in the median rating of students' overall levels of preparedness across the different clinical placements

- establish links between assessment outcomes as evidenced by block marks and students' perceived preparedness.

Method

Design

This was a descriptive study utilising prospective student questionnaires to determine subjective perceptions and clinical test marks for the objective measures of performance.

Participants

The study took place over 2 years, with participants from 2 different cohorts of 3rd-year students being recruited. Students were asked to volunteer to participate in the questionnaire after being explained its purpose by the researchers, who were permanent clinical educators. Students repeating the 3rd-year clinical course were excluded from the study as only initial readiness for practice was being assessed.

Instrumentation

Questionnaire

A self-developed questionnaire was used which consisted of 17 items related to key areas of novice competence. Items were chosen based on the literature^[9,12,13] and the researchers' own experiences in dealing with 3rd-year students entering clinical practice for the first time. The areas of readiness were broadly linked to the following components:

- theoretical knowledge of conditions seen in the clinical placement
- planning – which included questions on ability to obtain relevant information from patient folders, conduct a subjective and an objective evaluation, and identify and analyse patient problems
- intervention – which included execution and adaptation of practical skills and decision-making on treatment length
- generic competencies such as communication, time management, confidence and emotional readiness
- measure of perceived overall readiness for practice.

Answers were rated on a Likert scale from 1 to 5. The responses were made anonymously, but students were asked to provide their gender and in which clinical area they were placed. (There were 4 - 17 students in each placement, so identification of student responses was not possible.) A senior lecturer in the Education Development Unit, UCT, reviewed the questionnaire to ensure content validity. It was then piloted on 10 4th-year physiotherapy students. Feedback from the pilot study resulted in some minor grammatical changes being made.

Testing procedure

The questionnaire was administered in a lecture venue during the penultimate week of the first clinical block. Participants were informed of the purpose, benefits and risks of the study, as well as their right to withdraw at any stage. All participants completed an informed consent form (Appendices 1 and 2). Questionnaires were handed out and collected by the researchers, but there was no interaction between the students and the researchers after the procedure had been explained.

Ethical considerations

Ethical clearance for the study was obtained from the Human Research Ethics Committee of the Faculty of Health Sciences, UCT (HREC ref. 157/2012). Students were assured of anonymity and that the information obtained would

be used by the researchers for the purpose of an article only.

Statistical analysis

Results from the 2 cohorts were amalgamated and entered into an Excel spreadsheet and imported into Statistica for analysis. The participants were grouped according to their first clinical block within one of the following areas: paediatrics, general hospital, NMS clinic, care of the elderly, and community. Descriptive statistics were used to describe the frequency of responses to each question. The internal consistency of the 17-item instrument was tested using Cronbach's alpha and, as this was high, at 0.847, the individual scores were added together and the mean score calculated for each student. An independent *t*-test was then used to compare the results of the two cohorts, and ANOVA was used to establish if there was a significant difference in different areas of competency, student scores on the block performance mark and on the questionnaire, across the different clinical settings.

Results

Demographics of the sample

There were a total of 93 students entering clinical practice – 50 in the 1st and 43 in the 2nd cohort. However, as repeating students had been excluded and only volunteering 3rd-years were included as participants, a total of 67 students took part in the study. Forty-one respondents were female and 18 male. Eight participants failed to indicate gender. The number of respondents was highest in paediatric areas (17) and lowest in community placement (4) (Table 1).

Students reported a median of 3 - 4 (moderate to good) preparation on every item (Table 2). They reported their own preparation for the block as good (median 4) and were confident in their ability to extract information from patients (median 4) and their folders (median 4). They were satisfied with their ability to communicate, both with

patients (median 4) and clinical staff (median 4), with 12 and 17 reporting excellent preparation in this area. Although their initial confidence levels were poor (median 2), these had improved to 'good' at the end of the block (median 4).

The mean scores for each section and the total score indicated that the components related to theoretical understanding and generic competencies (affect) had the highest mean score, whereas the students scored themselves lowest in terms of overall preparedness for the block (Fig. 1).

One-way ANOVA revealed that the students perceived that they were better prepared in some areas than others ($F(4, 264) = 4.8601, p < 0.001$). *Post hoc* analysis indicated that the difference was between the higher affect (generic skills) scores and the lower perception of preparation for intervention and overall preparedness.

Comparison of total questionnaire scores across placements

Although the scores in NMS were the highest, there were no significant differences between the mean scores of the different placements ($F(4, 53) = 0.804, p = 0.528$) (Fig. 2).

Mean score of clinical marks across the different clinical areas

There was no significant difference between the mean scores of the clinical marks allocated to the first cohort of students (67.3 ± 5.8) and the second

cohort ($68.03 \pm 6.5; t = -.54, p = 0.46$). They were therefore amalgamated and ANOVA indicated that there was also no significant difference in the mean scores across the areas ($F(4, 77) = 0.438, p = 0.781$) (Fig. 3). (Note that the marks of all students were included in this analysis and not only those who filled in the questionnaire.)

Discussion

The results indicate a surprisingly high perception of preparedness, by the majority of students, on starting their first independent clinical block. This was contrary to the expectations of the authors and to much of the literature.^[4,6,9,10,12,13] The scores are particularly high in the areas of communication with both patients and staff. It may seem contradictory that despite feeling prepared, the students' confidence levels were low at the start of clinical block. However, it would be unlikely that students who had never treated patients would feel confident before entering the clinical arena. They appeared to gain considerable confidence over the course of the block.

How realistic were the self-reports of clinical competencies? Some studies have linked the validity of self-reporting to actual ability.^[19-21] In this study, it appears that the students did not overestimate their own ability as the cohort achieved similarly satisfactory clinical mark scores from all the clinical placements, with an average ranging from 65 - 68% – a 'satisfactory'

Placement	n (%)
Hospital	13 (19.4)
Paediatrics	17 (25.4)
Care of the elderly	11 (16.4)
Neuromuscular skeletal	13 (19.4)
Community	4 (6.0)
Missing information	9 (13.4)
Total	67 (100)

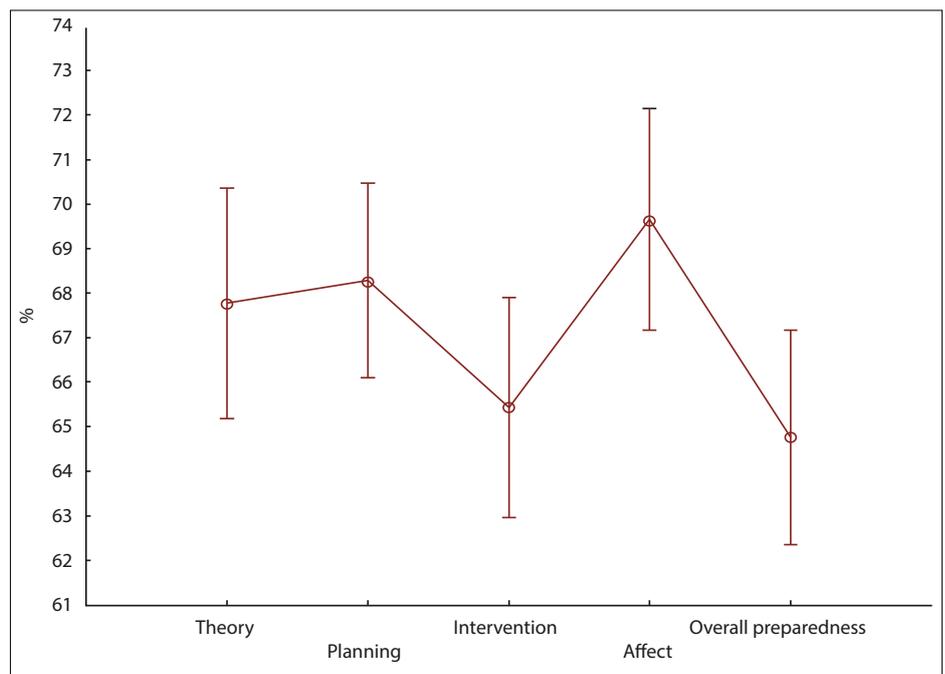


Fig. 1. Means and 95% CIs of the mean scores of each component (n=58; 9 missing). There is a significant difference between the scores ($p < 0.001$).

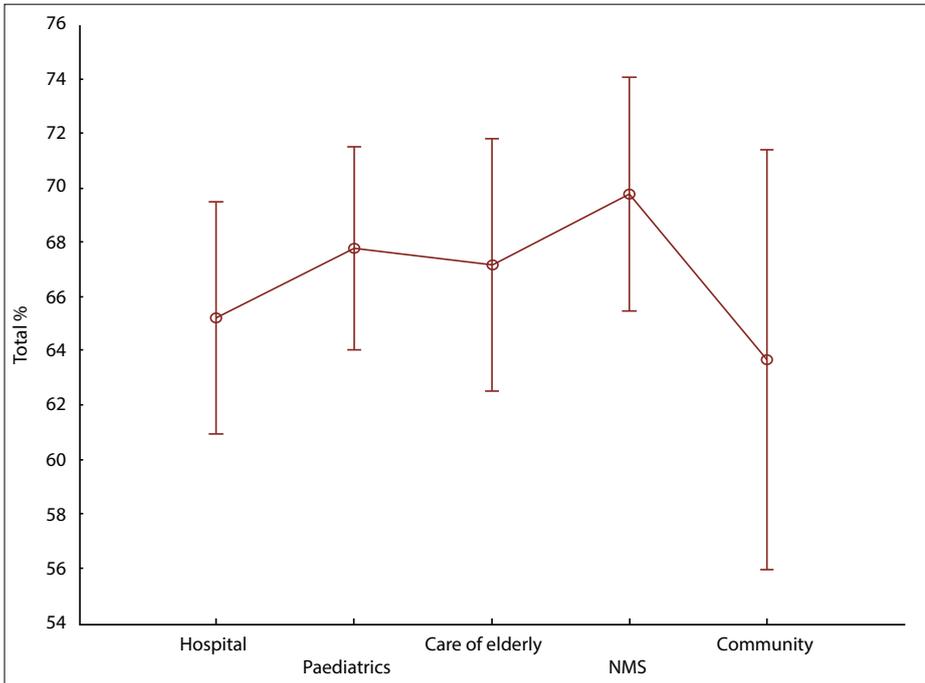


Fig. 2. Mean total scores per clinical placement area (n=58). (NMS = neuromuscular skeletal.)

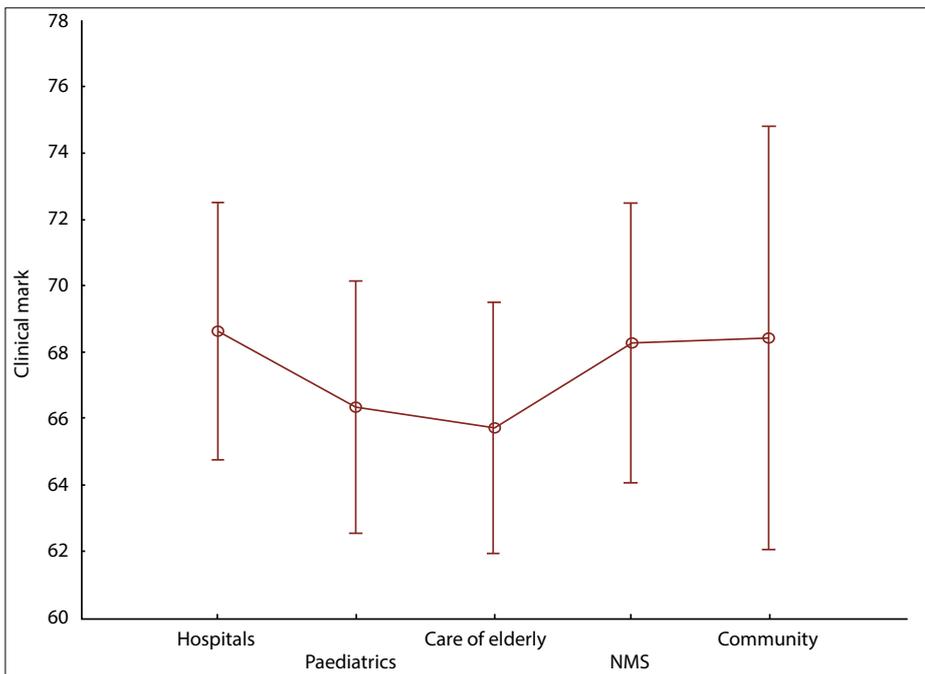


Fig. 3. Clinical marks across the placements (N=78 as all 3rd-year students in the 2 cohorts were included).

performance, according to marking guidelines. However, it is impossible to correlate scores when the replies were anonymous, and there might have been individual discrepancies between perception and objective measurement.

This sense of preparedness and competence can perhaps be attributed to an improved alignment between the taught curriculum and the needs of the

clinical arena, as discussed by other authors.^[4,7,11] Students confirmed that they had adequate and appropriate theoretical knowledge to manage the pathologies encountered in clinical practice. This alignment has been supported by the inclusion of clinical educators within academic teaching clusters, at UCT. These clusters meet regularly to review course content and objectives. Input

from clinical educators ensures that course content matches the health needs of the population, which students manage at clinical sites, as recommended by Stevens.^[22] By facilitating the link between the students' theoretical knowledge and its practical application, the clinical educators are able to build on the students' ability to implement and manage an intervention.^[4,23]

Interestingly, most students reported a low sense of perceived overall preparedness on starting their first clinical block; but, when asked to rate their preparedness for specific competencies in theoretical knowledge, planning, intervention and even generic skills (affect), they reported adequate levels of preparedness. This rating might indicate that, despite being anxious on starting independent clinical practice, they felt supported by the clinical educators throughout the block, ensuring a safe learning environment in which to implement their knowledge and improve their confidence in their abilities, as suggested by a systematic review of education models.^[17] Contrary to concerns in the literature that students were less prepared in terms of generic skills, the respondents reported a higher level of perceived competence in generic skills (affect) (with a mean score of just under 70%) than in areas of specific clinical competence in implementing an intervention (which has a mean score of just over 65%). Clinical educators are also ideally positioned as appropriate role models for students, by reinforcing professional behaviours and generic skills within the clinical arena,^[24] which could explain the students' confidence in these skills.

The appointment of permanent academic clinical educators with additional training in educational skills^[1] has resulted in a more standardised approach to supervision and a uniform understanding of the level of competence required to perform adequately within clinical practice at 3rd-year level. This conclusion is supported by the fact that there was no significant difference in students' overall preparedness or the marks obtained, across the different clinical placements. Similarly, there was no difference in marks between the two different cohorts. The consistency of clinical marks speaks to similar expectations among UCT clinical educators. Fewer students were placed in the community block as this is a new placement. The large confidence intervals in both the total scores and the clinical block placements are indicative of the small number of respondents and the need to develop an appropriate assessment for performance in a non-traditional physiotherapy training setting.

Table 2. Perceived competency: Median scores obtained on each question (N=67)

	Non-existent (1)	Poor (2)	Moderate (3)	Good (4)	Excellent (5)	Median	Range
Overall preparedness for block	0	2	47	18	0	3	2 - 4
Own preparation before block	0	4	28	32	3	4	2 - 5
Theoretical knowledge of conditions encountered	1	6	35	24	1	3	1 - 5
Ability to obtain information from patient folder	0	4	18	38	5	4	2 - 5
Confidence in subjective evaluation	0	3	19	38	7	4	2 - 5
Ability to objectively assess patients	0	10	37	19	1	3	2 - 5
Ability to identify patient problems	0	11	32	21	3	3	2 - 5
Ability to identify appropriate interventions	0	8	33	26	0	3	2 - 4
Adequacy of practical skills	0	7	39	20	1	3	2 - 5
Application of practical skills	1	11	34	18	3	3	1 - 5
Ability to adapt physiotherapy treatment	0	5	32	27	3	3	2 - 5
Ability to decide on cessation of treatment	0	8	34	23	2	3	2 - 5
Ability to communicate with patient	1	3	16	35	12	4	1 - 5
Ability to communicate with clinical staff	1	1	6	42	17	4	1 - 5
Time management skills	0	5	27	30	5	4	2 - 5
Initial confidence levels	2	34	24	6	1	2	1 - 5
Confidence level at end of block	0	2	15	42	7	4	2 - 5
Emotional preparedness for block	1	15	25	24	2	3	1 - 5
Average number of responses in each category	0.4	7.7	27.8	26.8	4.1		

Limitations of the study include the need to rely on self-reporting, which may produce biased results. In addition, the questionnaire was answered anonymously and consequently the responses could not be linked with the clinical performance marks. It might be that there is little correlation between perception of preparedness and objective clinical performance.

It would appear that, in general, the students at UCT are given adequate training, preparation and support within the academic and clinical arenas, enabling them to perform competently when independently responsible for patient management for the first time.

Conclusion

According to the literature in clinical education, students often struggle to make the transition from the classroom to the clinical arena.^[3,4,9-11] In contrast, this study demonstrates that 3rd-year physiotherapy students at UCT felt adequately prepared, across all aspects of clinical competencies, on their entry to clinical practice. The level of preparedness was not affected by which clinical setting they were sent to. This sense of preparedness was mirrored by their assessment marks, showing satisfactory averages across all clinical placements.

This sense of readiness speaks to the alignment of the classroom curriculum and clinical expectations within the Division of Physiotherapy at UCT, implying that the basic sciences, technical and generic skills, and application of ideas taught during the 2 preclinical years do align with the needs of the client population, seen at clinical placements. The alignment has come about through extensive curriculum review, leading to both horizontal and vertical alignment across the years of training. This has coincided with the appointment of permanent clinical educators, each specialising in a particular field, as vital links between the classroom and the clinical setting, which could have enhanced the preparedness of physiotherapy students at UCT.

We recommend that the integration of clinical and theoretical teaching be a major focus of physiotherapy training. The employment of academic, permanent clinical educators who, together with academic lecturers,

developed an appropriate curriculum has helped to bridge the gap between theory and clinical practice.

References

- Devlin M, Samarawickrema G. The criteria of effective teaching in a changing higher education context. *Higher Education Research & Development* 2010;29(2):111-124. [http://dx.doi.org/10.1080/07294360903244398]
- Laitinen-Väänänen S, Talvitie U, Luukka M-R. Clinical supervision as an interaction between the clinical educator and the student. *Physiother Theory Pract* 2007;23(2):95-103.
- Frantz JM, Rhoda AJ. Assessing clinical placements in a BSc physiotherapy program. *Internet Journal of Allied Health Sciences and Practice* 2007;5(3):1-6.
- Strohschein J, Hagler P, May L. Assessing the need for change in clinical education practices. *Phys Ther* 2002;82(2):160-172.
- Richardson B. The way forward – How and why? *Advances in Physiotherapy* 1999;1(2):13-16.
- Ernstzen DV, Bitzer E, Grimmer-Somers K. Physiotherapy students' and clinical teachers' perceptions of clinical learning opportunities: A case study. *Medical Teacher* 2009;31(3):102-115. [http://dx.doi.org/10.1080/01421590802512870]
- Ramklass SS. An investigation into the alignment of a South African physiotherapy curriculum and the expectations of the healthcare system. *Physiotherapy* 2009;95(3):216-223.
- Cross V. Begging to differ? Clinicians' and academics' views on desirable attributes for physiotherapy students on clinical placement. *Assessment and Evaluation in Higher Education* 1998;23(3):295-310. [http://dx.doi.org/10.1080/0260293980230306]
- Clouten N, Homma M, Shimada R. Clinical education and cultural diversity in physical therapy: Clinical performance of minority student physical therapists and the expectations of clinical instructors. *Physiother Theory Pract* 2006;22(1):1-15.
- Jones M, McIntyre J, Naylor S. *Physiotherapy* 2010;96(2):169-175. [http://dx.doi.org/10.1016/j.physio.2009.11.008]
- Broberg C, Aars M, Beckmann K, et al. A conceptual framework for curriculum design in physiotherapy education – an international perspective. *Eur J Physiother* 2003;5(4):161-168. [http://dx.doi.org/10.1080/14038190310017598]
- Cross V. The same but different. *Physiotherapy* 1999;85(1):28-39.
- Dean SJ, Barratt AL, Hendry GD, Lyon PM. Preparedness for hospital practice among graduates of a problem-based, graduate-entry medical program. *Med J Aust* 2003;178(4):163-166.
- Colbeck CL, Cabrera AF, Terenzini PT. Learning professional confidence: Linking teaching practices, students' self-perceptions, and gender. *The Review of Higher Education* 2013;24(2):173-191. [http://dx.doi.org/10.1353/rhe.2000.0028]
- Morgan PJ, Cleave-Hogg D. Comparison between medical students' experience, confidence and competence. *Med Educ* 2002;36(6):534-539.
- Rodger S, Webb G, Devitt L, Gilbert J, Wrightson P, McMeeken J. Clinical education and practice placements in the allied health professions: An international perspective. *J Allied Health* 2008;37(1):53-62.
- Lekkas P, Larsen T, Kumar S, et al. No model of clinical education for physiotherapy students is superior to another: A systematic review. *Aust J Physiother* 2007;53(1):19-28.
- Shear M, Sanders D, Van Niekerk R, Hobdell H, Reddy S. Education of health professionals for a restructured health system – whose responsibility should it be? *S Afr Med J* 1997;87(9):1104-1107.
- Barnsley L, Lyon PM, Ralston SJ, et al. Clinical skills in junior medical officers: A comparison of self-reported confidence and observed competence. *Med Educ* 2004;38(4):358-367.
- Spitzer R, Kroenke K, Williams J. Validation and utility of a self-report version of PRIME-MD. *JAMA* 1999;282(18):1737-1744.
- Mabe P, West S. Validity of self-evaluation of ability: A review and meta-analysis. *J Appl Psychol* 1982;67(3):280-296. [http://dx.doi.org/10.1037/0021-9010.67.3.280]
- Stevens DP, Kirkland KB. The role for clinician educators in implementing healthcare improvement. *J Gen Intern Med* 2010;Suppl 4:S639-643. [http://dx.doi.org/10.1007/s11606-010-1448-0]
- Oyeyemi AY, Oyeyemi AL, Rufai AA, et al. Physiotherapy students' perception of their teachers' clinical teaching attributes. *African Journal of Health Professions Education* 2012;4(1):4-9.
- Paice E, Heard S, Moss F. How important are role models in making good doctors? *BMJ* 2002;325(7366):707-710.

Appendix 1

Information and informed consent form for students

Dear Student

General Information

The study has been approved by the Faculty of Health Sciences Human Research Ethics Committee reference number 157/2012. The UCT clinical educators are attempting to improve the standard of clinical education by researching whether 3rd-year physiotherapy students are adequately prepared for clinical practice in their first clinical block. As part of the study, you will be asked to complete an anonymous questionnaire. The questionnaire will be administered during one of your lecture periods during your fourth week of clinicals.

In conjunction with the questionnaire, the researchers may need to access your marks from the 1st clinical block of 3rd year.

The information obtained from this questionnaire will be used solely by the researchers for the completion of a journal article and will not be made available to other parties.

Informed Consent

I confirm that the exact procedures and possible complications of the above research have been explained to me. I understand that I may ask questions at any time during the data collection. I realise that I am free to withdraw from the study without prejudice at any time, should I choose to do so. I have been informed that all the information required by the researchers will be held in strict confidentiality, and will be revealed only as part of statistical analyses.

I have carefully read this form. I understand the nature, purpose and procedure of this study. I agree to participate in this research project of the UCT clinical educators.

Name (in full) of student:

Signature:

Date:

Researchers:

Appendix 2

Questionnaire

Please complete the following:

Date of birth:

Sex (male/female):

Clinical block:

Using the scale **1=non-existent, 2=poor, 3=moderate, 4= good, 5=excellent**, please rate the comments below, by circling the number that best matches your opinion.

1. Rate your theoretical knowledge of the conditions you encountered on your first block	1	2	3	4	5
2. Rate your ability to obtain information from the patient's folders within the designated time period	1	2	3	4	5
3. Rate the confidence with which you were able to conduct a subjective evaluation	1	2	3	4	5
4. Rate your ability to objectively assess your patients	1	2	3	4	5
5. Rate your ability to identify your patient's problems	1	2	3	4	5
6. Rate your ability to identify appropriate interventions for the stated problems	1	2	3	4	5
7. Rate the adequacy of the range of practical skills you have been taught in the classroom.	1	2	3	4	5
8. Rate your ability to apply these practical skills when managing your patients on your first block	1	2	3	4	5
9. Rate your ability to adapt and/or cease physiotherapy treatment	1	2	3	4	5
10. Rate your ability to communicate effectively with the patients	1	2	3	4	5
11. Rate your communication with staff members at your clinical sites	1	2	3	4	5
12. Rate your time management while on the block	1	2	3	4	5
13. Rate your own preparation done before the block	1	2	3	4	5
14. Rate your initial confidence level in managing your first clinical block	1	2	3	4	5
15. Rate your confidence level towards the end of the block	1	2	3	4	5
16. Rate your emotional preparedness for managing situations faced on the first block	1	2	3	4	5
17. Rate your overall preparedness for the block	1	2	3	4	5