Hands-On Readiness Activities to Build Operational Competence & Productivity

Documentation labs, role-play exercises, and time-pressured workflows aligned to *From Classroom to Caseload* and widely used clinical education best practices.

1. Why Hands-On “Operational” Training Matters

From Classroom to Caseload emphasizes a predictable transition problem: learners may understand concepts, but struggle to execute under real constraints—time pressure, messy patient presentations, documentation standards, and rapid communication with supervisors. Hands-on activities make these constraints teachable by creating repeated reps in realistic conditions.

Program outcomes these activities target:

- **Operational competence:** learners can run a basic visit workflow reliably (start strong, prioritize, reassess, close with a plan).
- **Documentation competence:** learners can write objective, defensible documentation efficiently.
- **Communication competence:** learners can use structured updates (e.g., SBAR) with a clear request.
- **Productivity readiness:** learners understand how efficiency protects quality and sustainability.
- **Self-management:** learners can identify bottlenecks and apply “structure-first” adjustments.

Consider a Pre-Clinical Bootcamp

Definition: A **pre-clinical bootcamp** is a short, high-repetition training experience delivered **before** the first clinical day that targets operational execution (workflow, documentation speed/quality, and communication) under realistic constraints. It is not a content-heavy lecture; it is structured practice with timers, scripts, checklists, and rapid feedback.

See **Section 4** for bootcamp format options, time requirements, and implementation details.

2. Design Principles (Keep It Real, Keep It Repeatable)

- **Teach constraints on purpose:** time limits, incomplete information, interruptions, and competing demands.
- **Use short cycles:** brief instruction → practice → feedback → repeat (2–3 reps beats one long rep).
- **Grade for defensibility:** reward safe, clear, and consistent execution—not perfection.
- **Make "good enough" explicit:** show what acceptable documentation and communication look like in your context.
- **Debrief every time:** what happened, why, and the one change to test next.
- **Plan for no school instruction during clinicals:** concentrate practice pre-clinical and send learners with a Readiness Packet of tools and scripts.

3. Activity Menu (Pick 4–6 for a Pre-Clinical Bootcamp)

Activity 1 — Documentation Lab: From Vague to Defensible

Goal: Improve note quality and speed by training learners to write objective, measurable statements that link findings → intervention → response → plan.

- **Time:** 45–60 minutes
- **Materials:** 6–10 "bad note" phrases; one short patient vignette; your program's preferred format (SOAP, daily note, treatment note).
- **Setup:** Put learners in pairs. Give each pair the same vignette and a list of vague phrases.
- **Facilitator steps:**
    - Model **two example rewrites** out loud (showing the thought process: observable → measurable → relevant).
    - Pairs rewrite 6 phrases (10 minutes).
    - Swap papers; peers mark: observable? measurable? linked to plan? (10 minutes).
    - Pairs rewrite again under a time limit (5 minutes).

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    - Pairs rewrite again under a time limit (5 minutes).

- **Debrief prompts:** "Which phrases create legal/clinical risk?" "What words did you remove?" "What's the minimum necessary detail?"
- **Assessment (quick):** 0–2 scale each for objectivity, relevance, and plan linkage (total 0–6).

Sample "bad phrase" bank (edit to your discipline): tolerated well; progressing; improved strength; patient was educated; good participation; continues to have pain; will continue per POC.

Activity 2 — Timed Note Sprint: "Good Enough" in 8 Minutes

- **Goal:** Build speed and reduce after-hours note burden by practicing point-of-service capture and concise wording.
- **Time:** 30–40 minutes (3 rounds)
- **Materials:** a completed "visit data card" (subjective, objective measures, interventions performed, response, plan).
- **Rounds:**
  - **Round 1 (8 min):** write the note.
  - **Round 2 (6 min):** revise to remove nonessential narrative; keep defensible facts.
  - **Round 3 (5 min):** rewrite key sections only (assessment + plan) using tight language.

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- **Debrief prompts:** "What did you keep that didn't change clinical meaning?" "What must be captured in the moment?"
- **Assessment:** pass/fail for inclusion of required elements + no prohibited vague phrases (program-defined list).

Activity 3 — Role-Play: SBAR Help-Seeking Under Pressure (90 Seconds)

- **Goal:** Train concise, structured communication to a supervisor (clinical instructor, preceptor, charge nurse, attending, etc.).
- **Time:** 30 minutes
- **Materials:** 3 brief scenarios (see Appendix cases); SBAR template; timer.
- **Setup:** Triads: speaker (learner), supervisor (role-play), observer (scores).
- **Facilitator steps:**
  - Explain that the objective is clarity + a clear request, not "knowing everything."
  - Run 2 reps: Rep 1 with notes, Rep 2 without notes.
  - Observer scores using the rubric below; rotate roles.

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- **Debrief prompts:** “What detail was noise?” “Was the request explicit?” “What would you do next if the supervisor is unavailable?”
- **Assessment:** use the SBAR Micro-Rubric (below) and/or Checklist 3 in Section 3A.

Activity 4 — Role-Play: Attendance/Adherence Conversation (Neutral, Clear, Specific)

- **Goal:** Prepare learners for “business reality” conversations that directly affect outcomes and productivity (cancellations, no-shows, limited follow-through).
- **Time:** 25–35 minutes
- **Setup:** Pairs with an observer; rotate roles.
- **Script structure:** Align on goal → name the pattern → explain the why → offer options → agree on a specific plan.
- **Debrief prompts:** “Did the learner stay neutral?” “Was the plan specific?” “Did they preserve rapport while setting expectations?”
- **Assessment:** checklist: uses goal language; states pattern factually; asks barrier question; proposes a concrete plan; confirms understanding.

Activity 5 — Workflow Simulation: Run the Visit + Document in Real Time

- **Goal:** Integrate visit structure, patient interaction, and documentation habits under time pressure.
- **Time:** 60–75 minutes
- **Materials:** vignette; simple objective measure sheet; documentation template; timer.
- **Format:** 2 short “visits” (12–15 minutes each) with documentation windows built in.
- **Facilitator steps:**
  - Pre-brief: state objectives; set the fiction contract *(a brief agreement to treat the scenario as “real enough” for practice and to name assumptions/limitations out loud)*; clarify what “good enough” documentation means.
  - Visit 1: run scenario; pause twice for 60–90 seconds of point-of-service documentation.
  - Debrief 1: what broke down (time, clarity, documentation)? Choose one micro-adjustment.
  - Visit 2: rerun with adjustment; repeat documentation pauses.
- **Assessment:** look for an opening direction statement, a reassessment anchor, and documentation that matches what occurred.

Activity 6 — Efficiency Audit: Identify the Bottleneck (Not the Person)

- **Goal:** Teach learners to improve productivity through systems: reducing wasted motion, decision fatigue, and documentation sprawl.
- **Time:** 20–30 minutes
- **Method:** Provide a "day-in-the-life" timeline (e.g., 8 patients, 2 cancels, 1 eval, 30-minute lunch). Learners circle where time is lost and propose one system change.
- **Debrief prompts:** "What is the constraint?" "What can be standardized?" "What can be deferred or eliminated?"
- **Output:** One micro-change plan (e.g., pre-built note phrases, visit map first 5 minutes, end-of-visit closure routine).
- **Assessment:** use Checklist 6 in Section 3A to score the written micro-change plan objectively.

3A. Printable Scoring Checklists (Facilitator Handouts)

Facilitator instructions: Print and use the checklists below during bootcamp activities. Score only what is observable in the rep. Share 1–2 strengths and 1 targeted adjustment. When possible, re-run the rep so learners can apply the adjustment immediately.

Checklist 1 — Activity 1 (Documentation Lab: Vague → Defensible)

Learner: ___________________ **Date:** ___________ **Vignette:** ___________________		
Criterion	**Score (0–2)**	**Notes (what to adjust)**
Rewrites are **objective** (observable; no judgment words).	0 1 2	
Rewrites are **measurable/specific** when appropriate (numbers, distances, assistance level, reps/sets, duration, cues).	0 1 2	
Language is **relevant** (minimum necessary; avoids excessive narrative).	0 1 2	
Clear link: findings/intervention → **response** → **plan/next step**.	0 1 2	
Red flags present? (vague phrases retained; contradictions; missing response to intervention)	☐ Yes ☐ No	
One targeted adjustment for next rep: ____		

Checklist 2 — Activity 2 (Timed Note Sprint: "Good Enough")

Learner: ___________________ **Date:** ___________ **Round:** ☐ 1 ☐ 2 ☐ 3		
Required element	**Met?**	**Notes**
Subjective summary is brief and relevant.	☐ Yes ☐ No	
Objective measures/findings included (as applicable).	☐ Yes ☐ No	
Interventions described with enough detail to be defensible (what was done).	☐ Yes ☐ No	
Response to intervention captured (what changed / tolerance / performance).	☐ Yes ☐ No	
Plan/next visit focus is specific (what next, why).	☐ Yes ☐ No	
Avoids prohibited vague phrases (program list).	☐ Yes ☐ No	
Time target met? (Round 1: 8 min; Round 2: 6 min; Round 3: 5 min)	☐ Yes ☐ No	
One targeted adjustment: ____		

Checklist 3 — Activity 3 (SBAR Help-Seeking Role-Play)

Learner: ___________________ **Date:** ___________ **Rep:** ☐ With notes ☐ Without notes		
SBAR element	**Score (0–2)**	**Notes**
S — Situation is immediate and clear (why calling/interrupting now).	0 1 2	
B — Background includes only what is relevant (no story time).	0 1 2	
A — Assessment is coherent (what is being seen + what learner thinks it means).	0 1 2	
R — Request/recommendation is specific (confirm plan? safety check? prioritization?).	0 1 2	
Time — Delivered in ≤90 seconds.	☐ Yes ☐ No	
One targeted adjustment: ____		

Checklist 4 — Activity 4 (Attendance/Adherence Conversation Role-Play)

Learner: ___________________ **Date:** ___________ **Scenario:** ___________________		
Behavior	**Observed?**	**Notes**
Opens by aligning on the patient's stated goal.	☐ Yes ☐ No	
Names the pattern neutrally (attendance/home program) without blame.	☐ Yes ☐ No	
Explains "why it matters" in plain language (outcomes, progress, safety).	☐ Yes ☐ No	
Asks about barriers (and listens; does not immediately persuade).	☐ Yes ☐ No	
Offers options and lands on a specific plan (who/what/when).	☐ Yes ☐ No	
Closes by confirming understanding and next checkpoint.	☐ Yes ☐ No	
One targeted adjustment: ____		

Checklist 5 — Activity 5 (Workflow Simulation: Run the Visit + Document)

Learner: ____________________ **Date:** ____________ **Visit:** ☐ 1 ☐ 2		
Workflow anchor	**Observed?**	**Notes**
Direction-setting: states visit focus and what success looks like today.	☐ Yes ☐ No	
Prioritization: selects one key measure/target rather than doing "everything."	☐ Yes ☐ No	
Independent work: uses at least one patient task that creates clinician time.	☐ Yes ☐ No	
Point-of-service documentation: captures key data during the built-in pauses.	☐ Yes ☐ No	
Reassessment anchor: checks a key variable before closing.	☐ Yes ☐ No	
Closure: summarizes, sets next step/next visit focus, confirms understanding.	☐ Yes ☐ No	
Documentation matches the visit: note reflects what was actually done and observed.	☐ Yes ☐ No	
One targeted adjustment for rerun: ____		

Checklist 6 — Activity 6 (Efficiency Audit)

Learner: ___________________ **Date:** ___________ **Case/day timeline:** ___________________		
Objective requirement	**Met?**	**Evidence (write exactly what was submitted)**
1) Bottleneck is time-stamped: learner identifies one step where time is lost and records minutes lost (e.g., "Between visits 3→4: 12 minutes lost").	☐ Yes ☐ No	_________________________
2) Bottleneck is located in the workflow: learner names the workflow step (choose/describe): ☐ rooming/transition ☐ chart review ☐ documentation ☐ exercise setup ☐ patient education ☐ scheduling/coordination ☐ other: ____	☐ Yes ☐ No	_________________________
3) Root cause is stated as a process behavior (not a trait): written as "I/We do ____ (observable action) which causes ____."	☐ Yes ☐ No	_________________________
4) Micro-change is single and behavioral: written as one sentence starting with "For the next week, I will…" and includes a trigger (when/where) (e.g., "During rest breaks, I will document objective measures immediately").	☐ Yes ☐ No	_________________________
5) Implementation details included: learner lists one tool/template they will use OR one environment setup change (e.g., note template, saved phrases, visit map first 5 minutes).	☐ Yes ☐ No	_________________________
6) Metric is measurable: learner states one metric with a baseline and target (examples: "minutes between visits," "notes closed same day," "time to complete daily notes").	☐ Yes ☐ No	Baseline: ____ Target: ____
Facilitator decision: ☐ Pass (all 6 met) ☐ Revise (circle missing items: 1 2 3 4 5 6)		
One targeted adjustment for resubmission: ____		

Carry-forward plan: Send learners into clinic with the Self-Guided Clinical Readiness Packet (Appendix) and require a pre-clinical completion check. During clinicals, learners use the packet independently (weekly reset + scripts). If your program can collect anything during clinicals, keep it minimal: one weekly reset page or one de-identified documentation rewrite.

4. Suggested Implementation

Use this section to select a bootcamp format and operationalize delivery (staffing, materials, and a simple completion check). The goal is not to cover every clinical topic; it is to ensure learners can execute core workflows—documentation, communication, and visit structure—before they enter clinic.

Educator Steps (Minimum Viable)

- **Select 4–6 activities** from the Activity Menu that match the expected placement setting(s) and learner level.
- **Define "good enough"** for documentation and communication in your program (required elements, prohibited vague phrases, acceptable time targets).
- **Prepare 2–3 vignettes** (or use the provided scenarios) and create any discipline-specific data cards (objective measures, typical interventions).
- **Print materials**: tool templates, scripts, and the facilitator scoring checklists.
- **Set logistics**: room layout, timers, grouping plan (pairs/triads), and a simple rotation schedule.
- **Facilitate reps + debriefs**: run short cycles (teach → practice → feedback → repeat) and require one targeted adjustment per rep.
- **Run a completion check** using the Bootcamp Completion Check table below (including Readiness Packet completion) before learners enter clinic.

Format Options (Choose One)

Option	Recommended activity set	Deliverables (what learners leave with)
Half-day (~3 hours)	Activity 1 (Documentation Lab) + Activity 3 (SBAR) + abbreviated Activity 2 (Timed Note Sprint)	1 scored SBAR rep; rewritten phrase bank; "good enough" note example; packet expectations
1 day (~6–7 hours)	4–6 activities (typically single-pass reps), including Activity 5 (Workflow Simulation)	Completed note sprint (round 2 or 3); scored SBAR rep; workflow checklist feedback; readiness packet completion check
2 days (~12–14 hours)	All 6 activities + reruns + targeted remediation + capstone rerun of Activity 5	Two completed vignettes (visit map + note); scripts practiced; individual micro-change plan from Activity 6; readiness packet completion check

Staffing, Room Setup, and Flow

- **Staffing ratio (target):** ~1 facilitator per 10–16 learners for role-plays and timed reps. If staffing is limited, use peer observers with the printed checklists.
- **Group structure:** pairs for documentation labs; triads for SBAR and conversation role-plays (speaker/supervisor/observer).
- **Timers and rotations:** post time boxes visibly; run short cycles (teach → practice → feedback → rerun) whenever possible.
- **"Good enough" standards:** post required documentation elements and prohibited vague phrases; reinforce that clarity + defensibility outweigh length.

Materials Checklist (Educator Prep)

- 2–3 vignettes (or Appendix scenarios) + any discipline-specific data cards (objective measures, typical interventions, precautions).
- Documentation templates used in your program (SOAP/daily note/treatment note) or a standardized "visit data card."
- Printed SBAR templates and scripts (for help-seeking and patient conversations).
- Printed facilitator scoring checklists (Section 3A) + pens/highlighters.
- Timers (phone timers are fine) and a visible rotation plan.

Bootcamp Completion Check (Before Learners Enter Clinic)

Requirement	Evidence	Educator check
Documentation readiness	Completed note sprint (round 2 or 3) OR a short simulated note that includes required elements	☐ Pass ☐ Needs revision
Communication readiness	One scored SBAR rep with a clear request (≤90 seconds)	☐ Pass ☐ Needs revision
Workflow readiness	Completed Visit Map for one vignette + stated reassessment anchor + closure plan	☐ Pass ☐ Needs revision
Readiness Packet	Packet assembled (quick tools + scripts + weekly reset) and reviewed by learner	☐ Complete ☐ Incomplete

5. Appendix: Ready-to-Run Scenarios (Use Across Activities)

Scenario A — The Late Arrival + Incomplete Home Program

Prompt: Patient arrives 12 minutes late, reports doing the home plan "a couple times," and wants to "do the same things as last time." Learner must set direction, prioritize one objective measure, deliver a neutral adherence conversation, and document objectively.

Scenario B — The Inconsistency: High Pain Report, High Function

Prompt: Patient reports pain 9/10 but demonstrates near-normal movement and tolerates activity. Learner must identify the inconsistency, choose one safe next step, and provide an SBAR update to the supervisor with a clear question (e.g., red flags? progression?).

Scenario C — The Documentation Trap: Too Much Narrative

Prompt: Learner writes a long note but misses key objective measures and response to intervention. Task: identify what is missing, rewrite the assessment/plan in tight language, and complete a timed note sprint.

Scenario D — Pediatric School-Based: Competing Priorities + Limited Session Time

Prompt: Elementary-age student is pulled from class 8 minutes late due to a school assembly. Teacher says the student has testing later and "can't be too tired." Learner must: set a 1-sentence session focus, adjust the plan to the time constraint, communicate briefly with the teacher, document objectively for a school-based note, and state what will carry over to the next session.

Scenario E — Acute Care: Rapid Status Change + Escalation to the Team

Prompt: Adult inpatient seen for early mobility. Mid-session, the patient reports new dizziness and nausea; vitals are borderline and the patient looks less stable than at the start. Learner must: pause and prioritize safety, gather minimum necessary data, deliver an SBAR to the nurse/provider with a clear request, and document the event (what occurred, what was observed, actions taken, and response) in a defensible, objective way.

Scenario F — Home Health: Safety, Environment, and “Plan vs Reality”

Prompt: Older adult in home health with fall history. Home environment has clutter, poor lighting, and the patient declines using a recommended device (“It makes me look old”). Learner must: identify one top safety priority, use a neutral script to address risk and adherence, select one measurable outcome for today, and document objectively (environmental findings, education provided, patient response, and a specific next step). Add one efficiency move the clinician can standardize for future visits (template phrase, checklist, or closure routine).

Scenario G — Outpatient Ortho: High Volume Day + Documentation Spillover Risk

Prompt: Busy outpatient schedule: two back-to-back follow-ups, one new evaluation, and one cancellation that opens a 20-minute gap. Learner must: run a tight visit using the 3-Block Visit Map, complete point-of-service documentation during built-in pauses, and use the cancellation gap to close at least one note (without expanding documentation length). End with a brief efficiency audit: what would they standardize to prevent notes from stacking?

Scenario H — Inpatient Rehab / Behavioral Health Interface: Communication Breakdown

Prompt: Patient becomes frustrated and refuses to participate after a misunderstood instruction. Learner must: reset rapport with clear, respectful language; restate the plan in plain terms; offer a bounded choice (two options); and communicate the situation to the supervising clinician using SBAR. Documentation must reflect behavior and participation objectively (avoid labeling), and include the plan for the next session.

6. Sources Consulted (Public + Provided Materials)

- Paris, A. *From Classroom to Caseload: The Real-World Guide for New Allied Health Clinicians* (and associated materials available to the program).
- Institute for Healthcare Improvement (IHI): SBAR communication tool (Situation–Background–Assessment–Recommendation).
- Davis BP, Mitchell SA, Weston J, et al. SBAR-LA: SBAR Brief Assessment Rubric for Learner Assessment. *MedEdPORTAL* (open-access via PubMed Central).
- Eppich W, Cheng A. Promoting Excellence and Reflective Learning in Simulation (PEARLS) debriefing framework and tools.
- U.S. Department of Health & Human Services (HHS), Office for Civil Rights: HIPAA guidance and case examples emphasizing "minimum necessary."