Peer observation: A tool for continuing professional development

Deborah Davys, Vivienne Jones

Peer observation has been advocated as a means of monitoring and improving the quality of teaching in higher education, while peer support and review have been used to provide feedback and monitoring in the clinical context. The process of peer observation of practice in educational, managerial and clinical settings could facilitate improvements in all aspects of practice, have relevance as a tool for continuing professional development and help improve the quality of care for service users.

This article presents a background to peer observation and highlights its relevance to health-care professionals. A practical process to assist in the implementation of peer observation is outlined, with consideration to relevant contextual issues.

Key words: peer observation, continuing professional development, professional practice, monitoring

Davys D, Jones V (2007) Peer observation: A tool for continuing professional development ***14****(11): 489–93*

Peer observation is a form of peer review within teaching; a partnership in which colleagues observe each others' practice, provide feedback and engage in a discussion aimed to promote reflection (Bell, 2002). Other objectives include the identification of strengths and developmental needs, and the formulation of an action plan for further improvement (Hammersley-Fletcher and Orsmond, 2005).

Depending on the wishes of the person being observed, feedback may focus on general performance or more specifically on teaching and learning strategies, assessment or the achievement of learning outcomes (Hatzipanagos and Lygo-Baker, 2006). A further observation can be used to assess if intended improvements have been achieved. The process has potential benefit for both parties, since observers may incorporate observed good practice into their own teaching (Bell, 2002).

Peer support and peer review

Peer support is not a new concept and is a recognized model of supervision (Best and Rose, 1996). Warne (2002) defined it as a general term that may encompass any form of mutual support between people who provide useful feedback to each other. It may be used to monitor caseloads (Bannigan, 2000), review clinical reasoning skills (Clifford-Brown and Segal, 2004), and foster self-confidence and self-directed learning.

Relevance to practice

In the United Kingdom, the Health Professions Council (HPC) requires all health professionals to update their knowledge and skills in order to practise effectively and to protect the health and well-being of service users. There is much flexibility in how this can be achieved, e.g. supervision, mentoring, appraisal, student supervision, peer review and reflective practice (HPC, 2006).

Reflection is arguably the most widely-used self-evaluation strategy for continuing professional development (CPD) (Reid and McKay, 2001) and, while this teaches self-awareness and self-correction, others argue that it lacks rigour (Best and Rose, 1996) and is subjective (Jasper, 2003). Peer observation provides the opportunity for staff at all levels to work in pairs with the aims of eliminating ritualistic practice, directing personal development and ensuring that a safe, ethical and effective service is offered to service users. Feedback from service users involved in the session may provide further objectivity to the process.

AN APPROACH TO PEER OBSERVATION OF PROFESSIONAL PRACTICE

This article will provide a format for the process of peer observation, based loosely on a variety of models used in teaching, such as that used by the University of New South Wales (2006). This process comprises the following stages, each of which are

Deborah Davys
is Lecturer in Occupational Therapy, University of Salford
Vivienne Jones
is Lecturer in Occupational Therapy, University of Salford
Allerton Building
Frederick Road
Salford, M6 6PU
Tel (+44) 0161 295 2869/2463
Fax 0161 295 2432

Correspondence to:
D Davys and V Jones
D.Davys@salford.ac.uk
V.Jones@salford.ac.uk

described in more detail below:

- Selection of a peer as observer
- Agreement on aspects of practice to observe
- Observation
- Reflection upon the experience
- Feedback meeting
- Follow-up.

1. Selecting an observer

The observer should be a non-threatening individual, who has sufficient understanding of the other's role. Ideally this should be a more experienced colleague but could also be someone of broadly similar expertise and discipline (Claveirole and Mathers, 2003). Alternatively, an observer from a different professional background may provide an opportunity for inter-professional development and learning. Ultimately, the ability to give constructive feedback is the most helpful supervisory behaviour, regardless of seniority. The choice however, may be dictated by staff resources or by the specific aspect of performance to be observed. The pair may decide to observe each other's performance or it could be a unilateral arrangement.

2. Agreement on aspects of practice to observe

The peer pair should agree in advance on what aspects of practice will be evaluated. A date should be arranged and consent gained if the session involves service users. If not already agreed at departmental level, the peer pair should set mutually agreed ground rules regarding expectations, confidentiality and responsibilities of each party (Swain, 2007). There should however, be an agreement that any issues of concern or poor performance will be dealt with openly, especially if there are ethical implications. A form can be designed if formal feedback is desired, or alternatively, feedback could be verbal and in note form; the emphasis being on content rather than the form of delivery.

3. The observation

During the session the observer takes no active part but may make notes to aid feedback, or to complete the agreed form.

4. Reflection on the experience

Feedback could be provided immediately following the session, but it may be more beneficial to allow some intervening time for further reflection and evaluation by both parties.

5. Feedback

This should be a private and confidential meeting, allowing time for both parties to present their reflections and to consider strategies for further development. The potential for negative feedback and its implication for positive working relationships must be considered. With this in mind, the feedback should be non-judgemental and respectful, supportive but challenging (Hunter and Blair, 1999), and fair and honest. The process should never be punitive, and should focus on behaviour rather than the person to best support future performance. Getting the balance right is therefore important in ensuring the evaluation is not threatening (Bannigan, 2000). The observer, having reflected on the session, may recognize an opportunity to change and improve his/her own practice. Some form of confidential record of the process is recommended, and could be used as evidence for CPD purposes.

6. Follow-up

A truly accurate judgment is unlikely to be achieved on the basis of a single observation and as the aim of peer observation is to learn and improve practice, further opportunities are recommended to evaluate whether changes have taken place (Best and Rose, 1996). The time frame for follow up evaluations can be entirely flexible to suit the needs and constraints of the peer pair.

Further considerations

Peer review is a process that requires careful management. While it has the potential to be used as a developmental tool for both individuals and departments, staff may however, fear that it will be used in a judgmental way (Hammersley-Fletcher and Orsmond, 2005), or as an agenda for managerial control. All forms of evaluation create stress, and it is likely that both parties will experience some degree of anxiety in any supervisory relationship (Sweeney et al, 2001). Although anxiety can be a helpful motivator in terms of realizing one's potential (Bell, 2002), it can also generate resistance in staff who fear being deemed incompetent, especially if the process is imposed rather than available as a voluntary tool for improvement. The intention behind the observation process therefore needs to be clear. Peer observation as a voluntary scheme with an emphasis on individual control and choice of observer for the purpose of CPD is considered the most beneficial approach (Swain, 2007).

Benefits

The practice of peer observation may benefit the individual practitioner, service and service user in various ways. Peer support and review are important influences in both the recruitment and retention of staff (Waygood et al, 2000). Sweeney et al (p.382, 2001) noted that newly qualified staff in particular:

> **'appreciate a formal, structured and teaching-type approach to supervision'**

Therefore the voluntary opportunity to be observed

and receive feedback may be helpful in developing a sense of professional competency. This could be a natural development from the process of being supervised as a student, and indeed, could be used during education in student pairings or in educator/student partnerships, enabling the students to practise giving as well as receiving constructive feedback.

Peer observation may also be used to promote reflection upon practice at all levels, serving to enhance self-awareness and meet individual developmental needs (Hammersley-Fletcher and Orsmond, 2005). This may have particular relevance for experienced practitioners, who may find that increased expertise brings less opportunity for direct supervision and fewer opportunities for specific feedback. As the peer review process involves the reflection of a colleague whose view is detached and objective, this may stimulate more effective reflection-on-action (Schon, 1987) and practice could be improved as a result of this process.

Few health-care professionals will progress through their careers without minor performance issues at some time. If this can be recognized and accepted, it will become easier to deal with and hopefully provide a better quality service (Bannigan, 2000). Therefore peer observation can be used to recognize standards of work that are less than ideal and foster a supportive environment in which to address any such issues; as well as helping to meet the requirement for enhanced skills in supervision and mentoring, assessment and communication (College of Occupational Therapists, 2002).

Challenges

With the introduction of any process that aims to enhance quality and standards, there are issues that require careful consideration to avoid undermining the potential benefits. The consideration of relationships between observer and observed and the provision of feedback are two areas that must be managed with sensitivity. If the observation and feedback process is diluted, it may simply become a mutually supportive praise session for friends (Hammersley-Fletcher and Orsmond, 2005). Swain (2007) claims that positive feedback alone is non-productive; it therefore needs to be objective, constructive, and requires careful planning (Peel, 2005). Peer observation should focus on sharing and developing practice to the advantage of both parties and, ultimately, to the service user (Swain, 2007).

An additional concern for staff who participate in peer observation is that of being observed in a professional capacity by a colleague and the fear of receiving negative feedback or being deemed incompetent. According to Sweeney et al (2001) many therapists have a fragile sense of professional competence which could affect their willingness to engage with such a process. This anxiety is likely to be increased if the process is imposed rather than voluntary.

Some professionals consider peer observation to be undesirable as it emphasizes the issue of power balance between individuals (Hammersley-Fletcher and Orsmond, 2005). Clear guidelines and support are therefore necessary to reduce anxiety among staff and enable them to reap maximum benefit from the experience (Ellis, 2001). There is also a need for ground rules to deal with issues such as confidentiality (Swain, 2007). In addition, the provision of constructive feedback in a way that encourages and fosters improvement in practice is in itself a skill, and training in supervision is advocated for both parties (Ellis, 2001).

Time and resources

Although time and resources are the most frequently mentioned barriers to CPD, it is important to make time and set achievable short-term targets to attain or retain fitness to practice (Warne, 2002). In the equation of cost against benefit to all parties (Best and Rose, 1996), time is not a significant barrier: the peer observation process may be concluded within 2 hours (excluding time for personal reflection):

- Preparation: 30 minutes
- Observation: 30 minutes
- Feedback: 30–60 minutes

This equates to less than the half a day per month recommended for CPD by professional bodies such as the College of Occupational Therapists (2002).

Although two members of staff are involved in the process, the use of peer observation is cost-effective and less disruptive to service provision than absence for course attendance and accommodates individual pace and style of learning. It is important however, to consider the amount of time required for thorough preparation, dissemination of instructions and the establishment of appropriate ground rules.

CONCLUSION

All health professionals registered with the HPC are expected to provide a high quality service irrespective of their area of practice; be this clinical, managerial or educational. Health professionals therefore need to take personal responsibility for monitoring the standard of their own work (Bannigan, 2000). Peer observation of practice has potential benefits for all practice settings and can be used as a tool for professional development for both the observed individual and observer.

The concept of peer observation is not new and is used in differing degrees across the professions but most frequently in relation to higher education. The process can be beneficial to all grades of staff who have undergone some training in supervision and

are then able to provide each other with constructive feedback, encouraging learning through reflective practice. The process should not be imposed and it is important that the choice of pairing is left to the individuals. Used constructively, it is a valuable means of demonstrating CPD.

The benefits of adopting a policy of peer observation within a department may include increased confidence and skill for the observed individual and the opportunity for observers to implement good practice into their own work setting. Additionally, there could be positive implications for the recruitment and retention of staff, and the provision of a supportive environment in which staff can actively promote their own development and that of their colleagues. IJTR

Conflict of interest: none

Bannigan K (2000) To serve better: Addressing poor performance in occupational therapy. *British Journal of Occupational Therapy* **63:** 523–8

Bell M (2002) Peer Observation of Teaching in Australia. www.ltsn.ac. uk/genericcentre

Best DL, Rose ML (1996) Quality Supervision - Theory and Practice for Clinical Supervisors. WB Saunders Company Ltd, London

Claveirole A, Mathers M (2003) Peer Supervision: an Experimental Scheme for Nurse Lecturers. *Nurse Educ Today* **23**: 51–7

Clifford-Brown M, Segal B (2004) Peer Review Pilot. Letter: Occupational Therapy News **12**(1)

College of Occupational Therapists (2002) Position Statement on Lifelong Learning. *British Journal of Occupational Therapy* **65**: 198–200

Ellis G (2001) Looking at ourselves–Self assessment and peer assessment: Practice examples from New Zealand. *Reflective Practice* **2**: 289–302

Hammersley-Fletcher L, Orsmond P (2005) Reflecting on reflective practices within peer observation. *Studies in Higher Education*. **30**: 213–24

Hatzipanagos S, Lygo-Baker S (2006) Teaching observations: promoting development through critical reflection. *J Higher Educ* **30**: 421–31

Health Professions Council (2006) Continuing professional development and your registration. Health Professions Council, London

Hunter EP, Blair EE (1999) Staff supervision for occupational therapists. *British Journal of Occupational Therapy* **62**: 344–51

Jasper M (2003) *Beginning Reflective Practice*. Nelson Thornes, Cheltenham

Peel D (2005) Peer observation as a transformatory tool? *Teaching in Higher Education* **10**: 489–502

Reid A, McKay V (2001) Self-evaluation and occupational therapy fieldwork educators: Do they practise what they preach? *British Journal of Occupational Therapy* **64**: 564–71

Swain C (2007) Has someone got their eye on you? *The Times Higher Educational Supplement.* 9 March 2007

Schon D (1987) *Educating the Reflective Practitioner*. Jossey-Bass, San Francisco

Sweeney G, Webley P, Treacher A (2001) Supervision in occupational therapy, part 2: The supervisee's dilemma. *British Journal of Occupational Therapy* **64**: 380–7

University of New South Wales (2006) Peer Observation of Teaching.http://www.ltu.unsw.edu.au/content/teaching_support/peer_observation.cfm?ss=0 (accessed 25 October 2007)

Warne C (2002) Keeping in shape: Achieving fitness to practise. *British Journal of Occupational Therapy* **65**: 219–223

Waygood S, Beavis F, Mathewson S (2000) Clinical Governance at Gloucestershire Royal NHS Trust Occupational Therapy Service. *British Journal of Occupational Therapy* **63**: 535–8

COMMENTARY

The Royal College of Speech and Language Therapists recommends peer observation as a possible professional development activity for all practising speech and language therapists, newly qualified practitioners, returners to practice and support practitioners as part of adopting a wider 'reflective practice' ethos.

The Health Professions Council expects all health professionals to place service users at the centre of their continuing professional development (CPD) planning and to focus on how CPD will enhance their practice for the benefit of service users and the wider profession. Reflecting on learning events (formal CPD or work-based activities) as an individual is rewarding and helps to maintain an objective and focused approach to learning. However, sometimes 'we do not know what we do not know' and that is where we see the benefit of working in pairs for peer observation, peer review and collaboration.

Involving the service user in this process can also provide invaluable information; a service user may come into contact with many professionals during the course of their care and have the benefit of comparing their different experiences. Although the professionals may come from different disciplines, if the service user really is to be placed at the centre of care then peer observation is an essential tool for reflecting on how to improve working relationships and patient care pathways between these different disciplines.

We recommend that our members undertake our online e-learning courses in pairs or small groups to facilitate discussion, the sharing of ideas and informal feedback. Feedback from our focus groups have wholeheartedly welcomed this paired approach to online learning.

From a practical point of view, we have also discovered that therapists can be reluctant to provide critical evaluation to their peers, particularly if there is a perceived 'punitive' element. Therefore, we agree with the authors that peer observation should be structured, voluntary and done with an atmosphere of cooperation, mutual learning and with a view to sharing evidence-based practice.

Although 'peer observation' as a term may strike fear in to the hearts of some, we feel that it can in fact be an excellent mechanism for giving and receiving positive feedback between peers, and can help increase confidence and willingness to share good practice. This can be particularly valuable for professionals working in more isolated environments with challenging cases.

Finally, we believe that once you have 'squeezed all the goodness' from your learning activities using reflective practice techniques, it is essential that you share the knowledge you have gained. This could be quick verbal feedback at staff meetings, a compiled list from all the peer observation pairs in an organization/department/trust, writing for relevant journals, sharing through a special interest group or updating local and/or national best practice guidelines; the list could go on!

Dominique Lowenthal
Professional Development Services Manager
Royal College of Speech and Language Therapists, London
Dominique.Lowenthal@rcslt.org

KEY POINTS

- This article presents a brief background to peer observation of practice, peer review and peer support.
- The relevance of peer observation of practice to health-care professionals working at different levels within diverse contexts of practice is discussed.
- A practical process to assist in the implementation of peer observation of practice is outlined.
- Critical analysis of some of the issues surrounding peer observation of practice is presented.
- Time and resource implications of this process are reviewed.

COMMENTARY

The probable contribution of peer observation as a tool in the process of continuing professional development is clearly argued by Davys and Jones in this article. If it is to be used in the workplace it is essential to incorporate its use with student health-care professionals. Working alongside health-care staff and being observed is an expected part of the health-care student experience and as such, forms the basis for most practice assessment. A student observing another tends to be a more accidental occurrence and it is rare that it is explicitly required. When it is expected it is often linked to assessment rather than being an activity used specifically to promote professional development. These assessments often relate to the evaluation of competence and the associated challenges linked with this have been reported (Norcini, 2003).

Peer learning has been identified as an essential component in the education of beginning practitioners (Cohen and Sampson, 1999) with its potential to enhance and deepen academic learning and develop skills applicable to practice. The organization of some student placements should facilitate the possibility for peer observation and learning. In a review of 2:1 clinical placement models used in physiotherapy and occupational therapy practice education (Baldry Currens, 2003), where two students were placed with 1 clinical educator, students' appreciation of collaborative learning opportunities was felt to be the most consistent finding. However, peer observation within the 2:1 model has been reported as occurring spontaneously and less frequently as a facilitated, planned activity (Baldry et al, 2003).

The incorporation of effective peer observation into health-care students' practice learning environments requires careful planning and co-operation from those most directly involved with practice learning, i.e. clinical educators, mentors or supervisors. However, it is unlikely to be effective if its use in practice is not first developed within the academic learning environment. This may be within a framework of formative assessment or in problem-based learning where students' skills of self- and peer-assessment can be built into the learning experience. Feedback from peers' observations during problem-based learning can be used by students to inform the evaluation of their own performance.

Having a clear focus for the observation in the practice environment will ensure its purpose is explicit. McAllister (2003) provides a possible structure for peer exploration of clinical reasoning which is fundamental to the practice of many health-care professionals. Providing students with such a structure for the observed activity, what ever that activity may be, will help ensure that there is a clear medium for the sharing of experiences and the provision of useful feedback.

The inclusion of peer observation as a purposeful activity within health-care students' learning experiences should be encouraged. Familiarity with it will help ensure that its inclusion as part of the process of continuing professional development is seen as a positive and beneficial pursuit.

Dr Joanna Jackson
Head of Therapy and Programme Leader - MSc Physiotherapy (pre-registration)
Department of Health and Human Sciences
University of Essex
Wivenhoe Park
Colchester, CO4 3SQ

Baldry Currens J (2003) The 2:1 clinical placement model: review. Physiotherapy **89**: 540–54

Baldry Currens J, Bithell CP (2003) The 2:1 clinical placement model; perceptions of clinical educators and students. Physiotherapy **89**: 204–18

Cohen R, Sampson J (1999) Working together: students learning collaboratively. In: Higgs J Edwards H (eds) Educating beginning practitioners Challenges for health professional education. Butterworth Heinemann, Oxford

McAllister L (2003) Using adult education theories: facilitating others' learning in professional practice settings. In: Brown G Esdaile SA Ryan SE (eds) Becoming an advanced healthcare practitioner Butterworth Heinemann, Edinburgh

Norcini J (2003) Peer assessment of competence. Med Educ **37**: 539–43