Clinical Practicum

Supervisor: Office:
Phone:
Email:

Welcome to clinical practicum…(you can add your own message here).

Objectives

1. To gain experience evaluating and treating individuals who have communication disorders.
2. To develop and improve skills in the areas of:
    a. Therapy planning and implementation
    b. Writing goals, objectives, and other documentation
    c. Professional report writing
    d. Managing and interpreting data
    e. Self-evaluation of clinical skills
3. To provide an opportunity to use professional interactions skills with the clinical supervisor, parents/families, and other student clinicians.

    The knowledge, skills, and disposition criteria for this course are consistent with the ASHA standards for Clinical Competence in Speech Language Pathology and the Wisconsin Educator Preparation Standards.

    ASHA Standards for Clinical Competence in Speech Language Pathology

    1. To develop clinical skills in oral and written or other forms of communication sufficient for entry into professional practice. (ASHA Standard V-A)
    2. To develop clinical skill in providing intervention to clients with communicative and/or swallowing disorders (ASHA Standard V-B, 2a-g)
    3. To develop interaction and personal qualities for effective professional relationship with clients, families, caregivers, and other professionals (ASHA Standard V-B, 3a-c)
    4. To adhere to the ASHA Code of Ethics, and behave professionally (ASHA Standard V-B, 3d) https://www.asha.org/siteassets/publications/code-of-ethics-2023.pdf

    Wisconsin Teaching Standards:
    Standard # l Pupil Development: The teacher understands how pupils grow and develop, recognizing that patterns of learning and development vary individually within and across the cognitive, linguistic, social, emotional, and physical areas. The teacher designs and implements developmentally appropriate and challenging learning experiences for pupils.
    Standard #2 Learning Differences: The teacher uses his or her understanding of individual pupil differences and diverse cultures and communities to ensure inclusive learning environments that enable each pupil to meet high standards.

Standard #3 Learning Environments: The teacher uses his or her understanding of individual pupil differences and diverse cultures and communities to ensure inclusive learning environments that enable each pupil to meet high standards.
Standard #4 Content Knowledge: The teacher understands the central concepts, tools of inquiry, and structures of each discipline he or she teaches. The teacher creates learning experiences that make the discipline accessible and meaningful for pupils to assure mastery of the content.
Standard #5 Application of Content: The teacher understands how to connect concepts and use differing perspectives to engage pupils in critical thinking, creativity, and collaborative problem solving related to authentic local and global issues.
Standard #6 Assessment: The teacher understands and uses multiple methods of assessment to engage pupils in their own growth, to monitor pupil progress, and to guide the teacher's and pupil's decision making.
Standard #7 Planning for Instruction: The teacher plans instruction that supports every pupil in meeting rigorous learning goals by drawing upon knowledge of content areas, curriculum, cross-disciplinary skills, pedagogy, pupils, and pupils' communities.
Standard #8 Instructional Strategies: The teacher understands and uses a variety of instructional strategies to encourage pupils to develop a deep understanding of content areas and their connections, and to develop skills to apply knowledge in a meaningful way.
Standard #9 Professional Learning and Ethical Practice: The teacher engages in ongoing professional learning. The teacher uses evidence to continuously evaluate the teacher's practice, including the effects of the teacher's choices and actions on pupils, their families, other educators, and the community. The teacher adapts the teacher's practice to meet the needs of each pupil.
Standard #10 Leadership and Collaboration: The teacher seeks appropriate leadership roles and opportunity in order to take responsibility for pupil learning, to collaborate with pupils, their families, educators, and the community, and to advance the profession.

Before Clinic Begins

1. Stop by and see me for your clinical assignment where you'll receive a client information form (yellow sheet) and the client file review form. If you have a co-clinician, coordinate a time to stop by together. Please bring your schedule as we will discuss possible therapy times based on the client preferences and your availability.
    a. Once a time has been determined, contact the client/caregiver to set up therapy. Please do this before our initial supervisory meeting.
    b. When contacting the client/caregiver the first time, please use the phone in the CMC. If you get voicemail, please leave your name and personal cell phone number for a return call. This is a great time to review your voicemail greeting. You can continue to use the CMC phone if you prefer, but it does not accept voicemails. You can also email the client/caregiver. Please make note of your correspondence.
    c. Once a day/time has been determined, please sign up for a therapy room. Each room has a calendar and you can reserve a room for the semester. Directions are on the form. Please make note to share this with me and fill out a <u>white card</u> for the front office.

2. Please bring the following items to our initial supervisory meeting:
    a. Client review form (one per clinician)
    b. Ideas for initial session. You can utilize the Therapy Plan template on your S or P drive to finalize after we meet.
    c. Be aware of clinic policies and procedures as stated in the Clinic Handbook (CANVAS)

For Each Session

1. Written lesson plan
    a. What are the short term objectives you are targeting?
    b. What activities are you using? How do they support your goals?
    c. What supplies do you need?
2. Be in your therapy room no later than 15 minutes before your session. If someone is in your room up until your time, have materials ready to quickly move in.
3. Be in the lobby ready to greet your client at least 5 minutes before your session.
4. Clean up after each session. Wipe down tables, light switches etc. Also clean and sanitize all toys and materials.
5. Write SOAP notes immediately after your session if possible. Otherwise, complete your SOAP within 24 hours.

General Information Regarding Practicum

1. **Attendance**
   Since clinical practicum is an essential part of your clinical training, it is assumed that you will attend all of your weekly therapy sessions with your clients and any meetings with your supervisor. If for any reason you need to cancel a therapy session or a meeting with me, please let me know ASAP. You have my phone number, so there is no reason you should not be able to get in touch with me. You are responsible for contacting your client and the front desk. You may need to make up therapy sessions that you cancel.

2. **Weekly Supervisory Meetings**
   Supervisory meetings are held once a week. This is a time set aside for us to discuss your client and their management. Areas of discussion may include: any concerns regarding management or supervision of management; discussion of your client's response to therapy; problem-solving; therapy challenges; and self-evaluation of your performance. Stop in anytime if you have questions or concerns outside of our scheduled meeting.

3. **Therapy Plans**
   We will discuss therapy format at our first meeting. When planning out activities, think in terms of no longer 10-15 minutes per activity for a preschooler and be prepared for one activity to "bomb," so plan additional back up activities. For adults, be aware that conversation often IS the activity and therefore, not a "waste of time."

4. **Written Assignments**
   This course provides an opportunity for students to learn and improve their clinical writing skills. Students will complete a variety of written assignments including SOAP notes, self-evaluations, and therapy reports. This meets ASHA Standard V-A: The applicant must have demonstrated skills in oral and written or other forms of communication sufficient for entry into professional practice.
   During the semester, you will have opportunities to evaluate your own writing skills. You will revise your therapy report according to feedback given. You will also have opportunities to discuss my comments as they relate to your revisions.

5. **Data Collection**
   Data must be taken during each therapy session. This will be used in your SOAP note documentation. Please keep your data collection notes for the end of the semester.

6. **Reflection/Feedback**
   Complete daily self-evaluation within 24 hours after your session. These are designed to inspire true reflection of your session and critical thinking. This form can be found in either the S or P drive. If you are a clinician pair, you can both reflect on the same form, just initial the paragraphs.

7. **Video Self-Eval**
   You complete a video self-evaluation prior to midterm. Use the form in the syllabus. From this evaluation, we will generate 1-3 clinical goal(s) for you for the remainder of the semester. This is an opportunity for us to have open dialogue about what you see and perceive about your clinical skills.

8. **Observation**
   I will observe your sessions weekly and with more frequency at the beginning of the semester. The amount of time will ebb and flow as the semester progresses. After each observed session I will provide some short verbal or written feedback. More robust discussions can occur during our weekly meeting.

9. **Clock hours**
   Please track your clinical clock hours in a way that makes sense for you. We will compare time at the end when submissions are due.

10. **Co-Clinicians**
    The expectation with clinical partners is the workload is 50/50. This may mean that you take turns writing SOAP notes, calling family members or other professionals. You both must be actively engaged in the therapy session. You may be paired someone you don't know well or don't have much in common with. <u>It would benefit you to talk with your partner about learning styles, level of comfort with leading, extroverted, or introverted personality, attention to detail and timelines and outside responsibilities like work, classes, athletics etc</u>. This is an opportunity to learn, collaborate, compromise, and empower each other.

a. I will intervene if I observe one person controlling the session or hanging back and being too passive.
b. I will check-in with each clinician individually to talk about equity and shared workload
c. If you are having difficulty working with your co-clinician, please come see me, but only after you have had a mature discussion with your partner.

11. Telehealth

If clients are via telehealth, please get confirmation that this mode is still preferred. Work with me to make sure your email is permitted for longer zoom calls. Make sure you are in a location to ensure complete confidentiality. We can discuss more about best practices for serving our online clients.

12. Inclusivity Statement

It is my intent that students from all diverse backgrounds and perspectives be well-served by this course, that students' learning needs be addressed both in and out of class, and that the diversity that the students bring to this class be viewed as a resource, strength and benefit. It is my intent to present materials and activities that are respectful of diversity: gender identity, sexuality, disability, age, socioeconomic status, ethnicity, race, nationality, religion, and culture. Your suggestions are encouraged and appreciated. Please let me know ways to improve the effectiveness of the course for you personally, or for other students or student groups.

General Clinic Information

1. Dress Code

Students must adhere to the clinic dress code which is found in the Clinical Practicum Handbook on CANVAS.

2. Child Safety

a. Do not leave a child unattended (e.g., if have forgotten something, bring the client along)
b. An adult must be with children that are washing their hands
c. Do not let children stand on chairs, lean back on chairs, sit on counters etc.
d. Do not plan art activities that require glue guns
e. Encourage walking in the hallway for everyone's safety
f. Avoid using food as a reinforcer unless approved by the parent. Talk to me before planning cooking/baking activities
g. Monitor how the child uses the automatic doors
h. Consult with the me if you have questions on behavior management

3. Infection Control and Universal Procedures

Students must work to prevent the spread of infection/illness by properly cleaning the therapy room after each session. Students must use disinfectant wipes to clean all table surface, chairs, high-touch points (doorknobs, light switches) and all clinic materials that are to be returned to the CMC. Additionally, leave all doors open between session to allow for ventilation.

4. **Accommodations**
   Reasonable accommodations are available for students who have a documented disability. Please notify your supervisor and the Clinical Director during the first week of classes of any needs based disability that may require a reasonable modification for you to participate fully in this course. All accommodations should be approved through the Disability Resource Center (DRC) https://www3.uwsp.edu/datc/pages/apply-for-accommodations.aspx

5. **Professionalism**
   Your conduct, the attitude you display, and your attire influence your credibility as a professional. Being prepared, being organized, being respectful of individuals you interact with during your clinical experience (client, client's family, supervisors, other student clinicians, other associated professionals, etc.), and showing confidence and respect for others are important qualities. Students will have to follow the Clinic Dress Code and dress professionally. The Clinic Handbook can be found on CANVAS.

6. **CMC**
   Please be aware of the CMC policies and procedures for reserving and checking out materials. Utilize the graduate assistant on duty with any questions, concerns or material requests.

7. **Building Safety**
   Fire alarms will sound indicating you, and your client, should exit the building. If there is an active shooter, please release the magnet on the door jam, lock the door and turn out the lights. Await instructions from officials (don't open the door unless you know there is an all clear).

Grading

Students will be graded at the mid-term and end of the semester (except summer). A copy of the senior grading form can be found on CANVAS. Graduate students will be graded using CALIPSO. Graduate students must earn a B or better for clock hours to count.

A 95.5-100/4.27-4.49	B- 81-83.99/3.1-3.33	D+ 66.5-70.00
A- 91-95.49/3.96-4.26	C+ 78-80.00/2.72-3.0	D 61-66.49
B+ 88-90.99/3.65-3.95	C 74-77.99/2.5-2.71	F Below 61.0
B 84-87.993.34/3.64	C- 71-73.99	

OPTIONAL FORMS

COMPLETE AFTER OUR FIRST MEETING

You can find all of the pertinent information in your client's chart. Look through IEPs/IFSPs, past therapy reports, notes, etc. This may be written on typed. We will mainly be using it to guide our discussion.

Name:_____

Client's initials: ___ Client's Age _____ Client's DX_____

Summarize the case & discuss in broad terms the intervention plan. Make sure you look at final therapy reports, IEPs/IFSPs, medical reports, case history form, and other relevant information in the file. Think about the client as a total communicator, not a list of goals. How does the client communicate (strengths/weaknesses)? What does the client need to learn in order to communicate more effectively?

What else would you like to know about your client? How can you find out that information?

What areas do you need help with in getting started? Again, be specific here.

In your opinion, what are your clinical strengths? (If you haven't had clinic yet, what do you think they are?)

How much supervision and input do you feel that you need? (1=no supervision; 10=maximum supervision)

|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

1 2 3 4 5 6 7 8 9 10

Justify your response:

How would you define our roles as student clinician and clinical supervisor?

CLIENT FILE REVIEW COMPLETE BEFORE OUR SECOND MEETING

Name:_____

Based upon your review of the client's file, respond to the following questions:

Client's initials: ___ Client's Chronological Age _____ Client's DX_____

Referral Information:
(This should include referral source, date of initial referral, & reason for referral)

Developmental, Medical, Family History:

Summary of Previous Speech/Language Services:
(Mention previous services – school based services, birth to three, SLHC-UWSP, etc. Include length of time in therapy. Summarize most recent services.

Environmental and Educational History:
(Note current living situation and current education. What do your client's caregivers/client hope to see happen this semester)

What did you find out from the previous/current clinician(s)?
(Contact previous SLHC-UWSP clinicians and/or current clinicians from other facilities)

Note any teaching strategies discussed in the previous FTR:

Name_____

Video Self-Evaluation

Clinic

Please complete this individually and turn in a hard copy to me by the date indicated above. Be thoughtful and reflective.

1. Carefully observe your interaction with your client (and co-clinician, if applicable). Reflect on your body language, facial expression, and other nonverbal communication. How did you come across to your client and family members? Is there anything you would change?

2. Consider the intervention techniques you used. List a few techniques that you noted in your session and give a specific example for each. Were you satisfied with the variety and type of intervention techniques? Support your answer.

3. Consider your cueing hierarchy. Give at least one example in which you used several cues to get the desired response. What types of cues tended to be most beneficial?

4. What intervention techniques and/or activities tended to get the best response from your client? Speculate why. (Of course, this can vary widely from day to day).

5. Think about prompts and interaction style with your client. Specifically, were your questions yes/no (closed) or open-ended? Did you ask too many questions? Did you talk too much or too fast? Did you say “Can you?” when you should have said “Let’s…”? Did you pause enough to give your client time to respond or initiate? Did you teach and instruct your client or just test, test, test? Also consider the type of feedback/reinforcement and the frequency

6. What clinical skill(s) would you most like to improve upon for the rest of the semester?

7. Brag on yourself! What did you see that made you feel confident and proud?

Starting Therapy Checklist

✓ Receive Welcome Email

✓ Read Syllabus in its entirety

❑ Meet me briefly (10-15 minutes) on the first day of the semester to get your clinic assignment. You can email me ahead of time to claim a specific time, or feel free to stop by at any time during that day.

o We will also talk about some scheduling considerations, including recommendations for dosage, day/time, and treatment room options.

❑ Complete a file review.

o You can complete a file review via ClinicNote by accessing case history and recent semesters' SOAPs and FTR under "Files." Ensure you are reading all files – including case history forms and IEPs.

o If you need additional information that you cannot find in ClinicNote, please check out the paper file from the front desk.

o Complete the "Client File Review Form" (Included below in this syllabus) and bring (hard copy or electronically) to our next individual meeting.

❑ Please schedule your therapy sessions ASAP by contacting the client/parents. Clinic begins the second week of the semester. Let me know when you have it scheduled ASAP and sign up for the therapy room (by adding your name/time to the sheet on the door).

❑ Fill out clinic card (found at the front office) and hand-in to Mrs. Skebba.

❑ Schedule a 45-minute meeting with me to discuss the background information on your client and your plan for the first day of therapy. This should happen toward the end of the first week of the semester.

o If you have a partner, please coordinate this so that you are both present.

o Complete the attached "Client File Review" and bring to this meeting.

o Have your lesson plan for the first session drafted by this time.

o Be prepared to discuss the following issues: Any questions you may have regarding the client's disorder and therapy; questions we need to have answered regarding the client/disorder to assist in treatment planning; a general plan for the first two sessions.

❑ Let me know what questions, concerns, thoughts you have as you prepare for your first session!

Midterm Checklist

❑ Receive email alerting you to begin the midterm process. This will be sent out the week of xxxx.

❑ Following the email's instructions, sign up for a midterm meeting with me for the week of xxxx-xxxx (Partners should sign up for these meetings as individuals).

❑ Ensure access to the "Resources for Clinicians" folder, looking over forms in the "Midterm" subfolder. (All forms needed for the midterm process are located here.)

❑ Review the appropriate grading form to familiarize yourself with the skills that I am tasked with grading (Graduate students, use "Grad Student Calipso Worksheet;" Undergrads use "Undergrad evaluation worksheet"). You are not required to turn this in.

❑ If in-person, record a session to watch for completion of the "Student Self-Evaluation" form. If 100% teletherapy, plan a time to complete the self-eval as soon after a session as possible (so that it is fresh in your mind).

❑ Write 2 objectives for yourself as a clinician (at the bottom of the "Student Self-Evaluation Form.") Make these meaningful, measurable, and attainable by the end of the semester.

o Examples: "I will read 2 evidenced-based articles related to my client's disorder and implement at least 2 strategies into therapy." "I will develop a family-friendly home program for my client to promote carryover in the client's home." "I will develop a data sheet that can be used effectively every session to gather quantitative and qualitative data on my client's performance."

❑ Email or hand-in your Student Self-Evaluation form at least 24 hours before our scheduled meeting.

❑ Attend your scheduled meeting with me. This will take about 30 minutes.

❑ Billing forms are also due around this time – look for an email from myself and/or Ms. Skebba about when to fill these out.

Ending Therapy Checklist

❑ Determine when you will hold your last session. Clinic ends the week xxxxx.

❑ Confirm the final session with client/caregivers and schedule a time during that last session to hold the final meeting.

o Please coordinate this with my schedule to ensure my availability during that time as well.

❑ Prepare the visual information that is needed for the final meeting with caregivers. (For some, that may be a chart of progress and a list of procedures; for others, the whole FTR may be required).

o Regardless, ensure your post-baseline results are completed and ready to be discussed with client/caregivers during the final meeting. This means that ideally you are not leaving your final baselining for the last session.

❑ Have your yellow sheet (i.e., "Case Recommendations") available during your final meeting to ask client/caregivers about interest for fall semester.

❑ Following the final meeting with clients/caregivers, finalize FTR and send me an email when it is ready for me to print.

❑ Complete final SOAP note and fill out billing form, checking your dates/times for the second half of the semester.

❑ Schedule a final meeting with me to go over paperwork and grades (plan for 30 minutes).

❑ Submit hours via Calipso, preferably before the final meeting with me.

❑ Attend your final meeting, bringing your Billing Form and yellow sheet. Be sure your FTR is signed on ClinicNote

❑ Congrats! Enjoy your time off!

Tentative Schedule:
(subject to change depending on the needs of your client)

Week of xxxx	Getting started, e.g., meet together, schedules, room assignments, etc.
Week of xxxx	Baseline/pre-test; rough draft of objectives for your client; begin therapy syllabus
Week of xxxx	Solidify LTGs and STOs
Week of xxxx	Video self-evaluation is due at the end of the week
Week of xxxx	Midterm evaluation--I'd like for your video self-evaluations to be completed prior to the midterm conference
Week of xxxxx	First draft of the beginning of your Final Therapy Report is due. See Canvas for form. It should include: • all necessary identifying information, • background information (this section usually includes when the client was referred, by whom & why, a brief description of those initial concerns, when client began to receive therapy, and a brief statement on their progress) • Status at the beginning of therapy (this section usually contains information from your initial testing/observations; and • your goals and objectives written in standard format and reflecting your baseline information).
Week of xxxx	Final conferences; final therapy report due in completed form after the conference

Documentation Guide for SOAPS

1. Documentation of time

Begin each daily note by stating the amount of time spent with the client. For example,

The client was seen for 65 minutes

2. Documentation of Consent (tele-therapy)

The client agreed to have this session conducted through tele-therapy

3. SOAP format

(S) Subjective

All relevant information stemming from the session that is not measurable. Not measurable does not suggest unimportant. This would include client or family member comments of success or struggle. In addition, please add your thoughts on their perceived attitude, motivation and level of cooperation. *The client was pleasant, cooperative and well-motivated. Or, The patient's spouse reports improved word finding skills during conversation with friends.*

(O) Objective

All relevant information derived from the session that is measurable. For example, *client was accurate in 65% attempts with minimal assistance when naming her grandchildren*. In theory, you (present in the therapy room) and I (watching remotely) should be able to write the same objective statement.

(A) Assessment

As an SLP, what is your SLP interpretation of the above information? The assessment section is not a reiteration of the above, nor should it ever contain information that is not referenced in either S or O.

The assessment section is your professional opinion, as an SLP, of the current state of the client. For example, *XX persists with expressive > receptive aphasia as evidenced by chronic word retrieval struggles. These word finding issues limit his participation in his areas of responsibilities and desired interests related to verbal expression. It should be noted, however, that XX was benefitted by the provision of phonemic cues to elicit the target word.*

(P) Plan

The plan indicates the specific recommended direction that the therapist and client should take on subsequent session(s). To write, *"Continue with plan of care" is inadequate. Instead, "Continue with provision of phonemic cues to assist with word finding skills toward stated expressive language goals, instruct family members as able."*

Please remember that at the conclusion of the session, you have the responsibility to create a document, that has legal standing. Your documentation should provide answers to the following questions from a speech pathologist's perspective:

What did I see?

What did I hear?

What did I do in response to what I saw and heard?

What impact did my response have upon the patient and their performance?