Credentialed Clinical Instructor Program

American Physical Therapy Association
Materials included in this manual initially were developed in 1996 based on a grant provided by the American Physical Therapy Association (APTA) under principal investigator Michael J. Emery, PT, EdD, with co-investigators Nancy Peatman, PT, JD, MEd, and Lynn Foord-May, PT, MSPT, PhD, MEd, and based upon resources developed by the New England Consortium of Academic Coordinators of Clinical Education Inc. APTA is most appreciative of the diligent work and tenacious effort these individuals have provided in developing the original version of this manual and acknowledges their substantial contributions toward the overall process of developing a national voluntary clinical instructor education and credentialing process.

With this third edition of the Credentialed Clinical Instructor Program Manual, the content has been revised to remain contemporary with education, practice, and educational research, and consistent with language and terminology found in APTA documents and federal and state regulatory and legal information and guidelines. APTA Clinical Instructor Education Workgroups (CIEW) review and evaluate various aspects of the APTA Credentialed Clinical Instructor Program as required. In addition, program modifications are made based upon participant and credentialed clinical trainer feedback.

After completing this program, you will be able to:

- Describe the parallels between the characteristics of the practitioner and clinical educator.
- Plan and prepare for students during their clinical education experiences.
- Identify student learning needs and areas of competence.
- Design high-quality learning experiences for students at all levels of experience.
- Implement clinical teaching methods and supervisory techniques that support ongoing adult learning.
- Provide effective formative and summative evaluation.
- Identify legal and supervisory implications for clinical educators, including issues presented by ADA legislation, Medicare regulations, and the Patient's Bill of Rights.
- Manage the student who is demonstrating problem or exceptional performance.

The Assessment Center component of this program allows physical therapists and physical therapist assistants to apply information from the education program in simulated situations. Successful completion of all stations in the Assessment Center results in the awarding of APTA Clinical Instructor credentialing. The 6 stations of the Assessment Center have been integrated into the program schedule. As a reminder, it is essential that all physical therapists and physical therapist assistants participating in this program attend all sessions of the CCIP course and Assessment Center in its entirety to be eligible for credentialing.

This program and its contents are copyrighted and, therefore, cannot be reproduced for any other purpose without the written consent of APTA. Several forms may be copied, however, for use in the clinic when working with students. The only forms that may be duplicated for your use without prior permission are:

- The Anecdotal Record
- Summary Weekly/Planning Form
- Learning Contract
- Student Program Planning Flowchart
- Memorandum of Agreement
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SECTION I

The Clinician as Clinical Educator
SECTION I
THE CLINICIAN AS CLINICAL EDUCATOR

Introduction
Section I describes the relationship between the academic program, the clinical site, and those involved in the clinical education of students. It further describes the parallels in the roles of the clinician and the clinical instructor (CI). Characteristics of effective clinicians and CIs are discussed, and the responsibilities of the CI are identified. Section I provides a framework on which subsequent sections will build.

Objectives
After completing Section I, you will be able to:

1. Describe the partnership that exists between the academic program and the clinical site.
2. Identify the role and relationships of the ACCE/DCE, CCCE, CI, and student within physical therapy education.
3. Explain the role of the clinical educator as defined by the assumptions about clinical education.
4. Identify at least 4 characteristics of an effective CI.
5. Recognize the similarities in the roles of the clinician and clinical educator.
6. Identify core values in professionalism.
7. Incorporate the voluntary APTA Guidelines and Self-Assessments for clinical instructors.

Assumptions
1. The relationship between an academic program and the clinical site is a voluntary partnership.
2. Successful clinical experiences require that each “player” fulfills his or her role and responsibilities and follows established lines of communication in a timely manner.
3. The CI is the student’s role model throughout the course of his or her training.
4. Clinical education is an essential component of professional education that complements academic education.
5. Clinical education addresses all essential areas of physical therapist (PT) and physical therapist assistant (PTA) education:
   a. Professional behaviors and attitude
   b. Safety
   c. Interpersonal relationships and communication skills
   d. Problem-solving processes
   e. Clinical performance skills
   f. Administration/management
7. A goal of clinical education is to provide an environment that fosters a student’s professionalism and encourages the development of an autonomous and competent clinician.
8. The clinical environment is designed to promote adult learning.
9. The role of the clinical educator parallels the role of the clinician.
A. Clinical Education in Physical Therapy Education

VOLUNTARY PARTNERSHIP

The voluntary partnership between an academic program and the clinical site is contractual and includes:

- CI development and training,
- consistent and effective communication,
- knowledge about clinical education objectives,
- strategies for alternative models for the delivery of clinical education, and assessment of congruence between clinical facilities and the curriculum.

B. “Players” in Clinical Education

HEALTH CARE AND HIGHER EDUCATION SYSTEMS

C. Roles and Responsibilities

Academic Coordinator/Director of Clinical Education (ACCE/DCE): An individual who is responsible for managing and coordinating the clinical education program at the academic institution, including facilitating development of the clinical education site and clinical educators. This person is also responsible for coordinating student placements, communicating with clinical educators about the academic program and student performance, maintaining current information on clinical education sites, and assessing overall outcomes of the clinical education program. Unique faculty roles assumed by the ACCE/DCE beyond those of core faculty (teaching, service, and scholarship) include development of student clinicians, development of clinical education faculty, development and assessment of the clinical education program, management and coordination, leadership and collaboration, communication, and professional behaviors. Tools designed for those who interact with the ACCE/DCE to assess his or her performance are available for use.

Center Coordinator of Clinical Education (CCCE): Individual(s) who administers, manages, and coordinates clinical instructor assignments and learning activities for students during their clinical education experiences. In addition, this person determines the readiness of clinicians to serve as clinical instructors, supervises experiences, communicates with the academic program regarding student performance, and provides essential information about the clinical education program to physical therapy programs. He or she may or may not be a physical therapist.

Clinical Instructor (CI): An individual at the clinical education site who directly instructs and supervises students during their clinical learning experiences. This individual is responsible for carrying out clinical learning experiences and assessing students’ performance in cognitive, psychomotor, and affective domains as related to entry-level clinical practice and academic and clinical performance expectations. (Synonyms: clinical teacher; clinical mentor; clinical tutor; clinical supervisor)

Student: A learning worker who participates in clinical education to practice what he or she has learned in the classroom.
D. Rights and Privileges of Partnership

Physical therapy programs offer clinical instructors benefits or incentives for serving as CIs for their PT and PTA students.* Benefits or incentives may include:

- Access to texts
- Opportunity to conduct clinical research with academic faculty
- Continuing education offerings
- Continuing education units (CEUs) toward licensure renewal
- In-services provided by academic faculty at the clinic
- Library access, where available
- Opportunity to serve on a Clinical Education Advisory Committee
- Opportunity to serve as a lab instructor or guest lecturer on a specific topic
- Reduced tuition for postprofessional degree program
- Recognition as adjunct faculty appointment
- Access to website for clinical educators

*Since benefits or incentives vary for each academic institution, check with the physical therapy program with whom you affiliate to determine if you are offered any CI benefits or incentives.

E. Characteristics of Clinicians and CIs

1. Characteristics of Effective Physical Therapists
   a. Enjoy their work/have a positive attitude
   b. Are flexible
   c. Are open/caring
   d. Are well-disciplined in the setting/organized
   e. Are confident in their ability and knowledge
   f. Have a good sense of humor
   g. Are open to ideas
   h. Are caring
   i. Are friendly

2. Clinical Instructor Behaviors
   a. Communication behaviors
   b. Interpersonal relations
   c. Professional skills
   d. Teaching skills
# Activity 1

**Clinical Instructor Behaviors Self-Assessment**

<table>
<thead>
<tr>
<th>Communication Behaviors</th>
<th>1=low</th>
<th>2=moderate</th>
<th>3=moderate</th>
<th>4=moderate</th>
<th>5=high</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Makes himself/herself understood</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Provides useful feedback</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Is an active listener</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Provides positive feedback on performance</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Communicates in a non-threatening manner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Openly and honestly reveals perceptions that the clinical instructor has of the student</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Provides timely feedback</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Is open in discussing issues with the student</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Teaches in an interactive way; encourages dialogue</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Provides feedback in private</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interpersonal Relations Behaviors</th>
<th>1=low</th>
<th>2=moderate</th>
<th>3=moderate</th>
<th>4=moderate</th>
<th>5=high</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establishes an environment in which the student feels comfortable</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Provides appropriate support for student concerns</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Is empathetic</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Demonstrates a genuine concern for patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Presents student as a professional to others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Demonstrates positive regard for student as a person</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Skills Behaviors</th>
<th>1=low</th>
<th>2=moderate</th>
<th>3=moderate</th>
<th>4=moderate</th>
<th>5=high</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Employs physical therapy practice with competence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Demonstrates professional behavior as a member of the health care team</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Demonstrates a systematic approach to problem-solving</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Explains the basis for interventions based on evidence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Explains physiological basis of physical therapy examination</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Demonstrates appropriate role of physical therapy as part of health care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Serves as an appropriate role model</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Manages own time well</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Demonstrates leadership among peers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
### Activity 1 (Continued)

**Teaching Behaviors**

1. Provides the student with progressive learning opportunities and situations 1 2 3 4 5
2. Is available to the student 1 2 3 4 5
3. Makes the formal evaluation a constructive process 1 2 3 4 5
4. Makes effective learning experiences out of situations as they arise (teachable moments) 1 2 3 4 5
5. Plans effective learning experiences 1 2 3 4 5
6. Provides a variety of patients 1 2 3 4 5
7. Questions/coaches in a way to facilitate student learning 1 2 3 4 5
8. Points out discrepancies in student’s performance 1 2 3 4 5
9. Provides unique learning experiences 1 2 3 4 5
10. Draws a relationship between academic knowledge and clinical practice 1 2 3 4 5
11. Is accurate and objective in documenting student performance evaluation 1 2 3 4 5
12. Assists the student to define specific objectives for the clinical education experience 1 2 3 4 5
13. Observes performance in a discrete manner 1 2 3 4 5
14. Schedules regular meetings with the student 1 2 3 4 5
15. Plans learning experiences before the student arrives 1 2 3 4 5
16. Manages the student’s time constructively 1 2 3 4 5
17. Is timely in documenting the student’s performance 1 2 3 4 5
18. Is perceived as a consistent extension of the academic program 1 2 3 4 5

### 3. Additional Clinical Instructor Characteristics Supportive to Student Learning

- Care
- Respect
- Empathy
- Providing clear expectations
- Being approachable
- Allowing room for the student to make mistakes.
Activity 2A
Examples of Learning Experiences
Briefly describe an example of an *ineffective* clinical learning experience using characteristics of CI from Activity 1.

Activity 2B
Examples of Learning Experience
Briefly describe an example of an *effective* clinical learning experience using characteristics of CI from Activity 1.
4. Absolutely Essential Factors

Listed below are a number of factors that were named as “absolutely essential” in clinical education by at least 50% of the respondents to a survey conducted by Moore and Perry. The respondents included new graduates, clinical instructors, center coordinators of clinical education, and academic coordinators of clinical education.

* = factor that was essential for beginning students
# = factor that was essential for advanced students

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Opportunity for students to practice patient care</td>
</tr>
<tr>
<td>b.</td>
<td>Atmosphere receptive to students</td>
</tr>
<tr>
<td>c.</td>
<td>Staff interested in teaching students</td>
</tr>
<tr>
<td>d.</td>
<td>Sufficient feedback on performance</td>
</tr>
<tr>
<td>e.</td>
<td>Students with a purpose</td>
</tr>
<tr>
<td>f.</td>
<td>Assignment sufficiently long to accomplish objectives</td>
</tr>
<tr>
<td>g.</td>
<td>Students who are well prepared</td>
</tr>
<tr>
<td>h.</td>
<td>Patient variety</td>
</tr>
<tr>
<td>i.</td>
<td>Talented staff</td>
</tr>
<tr>
<td>j.</td>
<td>Variety of educational experiences</td>
</tr>
<tr>
<td>k.</td>
<td>Opportunity for students to explore own objectives</td>
</tr>
</tbody>
</table>

F. Parallels in the Roles

Developing skill as a CI includes being aware of the parallels that exist between your role as a clinician and your role as a clinical educator.

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Clinical Instructor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral/history</td>
<td>Preplanning</td>
</tr>
<tr>
<td>Initial examination, evaluation, diagnosis, and problem identification</td>
<td>Student assessment/ problem identification</td>
</tr>
<tr>
<td>Long-term goals</td>
<td>Overall objectives</td>
</tr>
<tr>
<td>Short-term goals</td>
<td>Behavioral objectives</td>
</tr>
<tr>
<td>Plan of care</td>
<td>Learning experiences</td>
</tr>
<tr>
<td>Reexamination/progression of care and interventions</td>
<td>Formative evaluation/modification of performance with feedback</td>
</tr>
<tr>
<td>Outcome assessment/discharge</td>
<td>Summative evaluation</td>
</tr>
</tbody>
</table>

<------------------Unconditional positive regard------------------>
G. Role Modeling and Mentoring Professionalism in Physical Therapy

1. Core Values for the Physical Therapist
For each core value listed, a definition is provided with sample indicators (not exhaustive) that describe what one would see if the physical therapist were demonstrating that core value in his/her daily practice.

<table>
<thead>
<tr>
<th>Core Values</th>
<th>Definition</th>
<th>Sample Indicators</th>
</tr>
</thead>
</table>
| Accountability       | Accountability is active acceptance of the responsibility for the diverse roles, obligations, and actions of the physical therapist including self-regulation and other behaviors that positively influence patient/client outcomes, the profession and the health needs of society. | 1. Responding to patient's/client's goals and needs.  
2. Seeking and responding to feedback from multiple sources.  
3. Acknowledging and accepting consequences of his/her actions.  
4. Assuming responsibility for learning and change.  
5. Adhering to code of ethics, standards of practice, and policies/procedures that govern the conduct of professional activities.  
6. Communicating accurately to others (payers, patients/clients, other health care providers) about professional actions.  
7. Participating in the achievement of health goals of patients/clients and society.  
8. Seeking continuous improvement in quality of care.  
9. Maintaining membership in APTA and other organizations.  
10. Educating students in a manner that facilitates the pursuit of learning. |
| Altruism             | Altruism is the primary regard for or devotion to the interest of patients/clients, thus assuming the fiduciary responsibility of placing the needs of the patient/client ahead of the physical therapist's self interest. | 1. Placing patient's/client's needs above the physical therapists.  
2. Providing pro-bono services.  
3. Providing physical therapy services to underserved and underrepresented populations.  
4. Providing patient/client services that go beyond expected standards of practice.  
5. Completing patient/client care and professional responsibility prior to personal needs. |
| Compassion/Caring    | Compassion is the desire to identify with or sense something of another's experience; a precursor of caring. | 1. Understanding the socio-cultural, psychological and economic influences on the individual's life in their environment.  
2. Understanding an individual's perspective.  
3. Being an advocate for patient's/client's needs.  
4. Communicating effectively, both verbally and non-verbally, with others taking into consideration individual differences in learning styles, language, and cognitive abilities, etc  
5. Designing patient/client programs/interventions that are congruent with patient/client needs.  
6. Empowering patients/clients to achieve the highest level of function possible and to exercise self-determination in their care. |
| Compassion/Caring    | Caring is the concern, empathy, and consideration for the needs and values of others. | 1. Focusing on achieving the greatest well-being and the highest potential for a patient/client.  
2. Recognizing and refraining from acting on one's social, cultural, gender, and sexual biases.  
3. Embracing the patient's/client's emotional and psychological aspects of care.  
4. Attending to the patient's/client's personal needs and comforts.  
5. Demonstrating respect for others and considers others as unique and of value. |
<table>
<thead>
<tr>
<th>Core Values</th>
<th>Definition</th>
<th>Sample Indicators</th>
</tr>
</thead>
</table>
| Excellence  | Excellence is physical therapy practice that consistently uses current knowledge and theory while understanding personal limits, integrates judgment and the patient/client perspective, embraces advancement, challenges mediocrity, and works toward development of new knowledge. | 1. Demonstrating investment in the profession of physical therapy.  
2. Internalizing the importance of using multiple sources of evidence to support professional practice and decisions.  
3. Participating in integrative and collaborative practice to promote high quality health and educational outcomes.  
4. Conveying intellectual humility in professional and interpersonal situations.  
5. Demonstrating high levels of knowledge and skill in all aspects of the profession.  
6. Using evidence consistently to support professional decisions.  
7. Demonstrating a tolerance for ambiguity.  
8. Pursuing new evidence to expand knowledge.  
9. Engaging in acquisition of new knowledge throughout one’s professional career.  
10. Sharing one’s knowledge with others.  
11. Contributing to the development and shaping of excellence in all professional roles. |
| Integrity   | Steadfast adherence to high ethical principles or professional standards; truthfulness, fairness, doing what you say you will do, and “speaking forth” about why you do what you do. | 1. Abiding by the rules, regulations, and laws applicable to the profession.  
2. Adhering to the highest standards of the profession (practice, ethics, reimbursement, Institutional Review Board [IRB], honor code, etc).  
3. Articulating and internalizing stated ideals and professional values.  
4. Using power (including avoidance of use of unearned privilege) judiciously.  
5. Resolving dilemmas with respect to a consistent set of core values.  
7. Taking responsibility to be an integral part in the continuing management of patients/clients.  
8. Knowing one’s limitations and acting accordingly.  
9. Confronting harassment and bias among ourselves and others.  
10. Recognizing the limits of one’s expertise and making referrals appropriately.  
11. Choosing employment situations that are congruent with practice values and professional ethical standards.  
12. Acting on the basis of professional values even when the results of the behavior may place oneself at risk. |
<table>
<thead>
<tr>
<th>Core Values</th>
<th>Definition</th>
<th>Sample Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Duty</td>
<td>Professional duty is the commitment to meeting one’s obligations to provide effective physical therapy services to individual patients/clients, to serve the profession, and to positively influence the health of society.</td>
<td>1. Demonstrating beneficence by providing “optimal care”. 2. Facilitating each individual’s achievement of goals for function, health, and wellness. 3. Preserving the safety, security and confidentiality of individuals in all professional contexts. 4. Involved in professional activities beyond the practice setting. 5. Promoting the profession of physical therapy. 6. Mentoring others to realize their potential. 7. Taking pride in one’s profession.</td>
</tr>
<tr>
<td>Social Responsibility</td>
<td>Social responsibility is the promotion of a mutual trust between the profession and the larger public that necessitates responding to societal needs for health and wellness.</td>
<td>1. Advocating for the health and wellness needs of society including access to health care and physical therapy services. 2. Promoting cultural competence within the profession and the larger public. 3. Promoting social policy that effect function, health, and wellness needs of patients/clients. 4. Ensuring that existing social policy is in the best interest of the patient/client. 5. Advocating for changes in laws, regulations, standards, and guidelines that affect physical therapist service provision. 6. Promoting community volunteerism. 7. Participating in political activism. 8. Participating in achievement of societal health goals. 9. Understanding of current community wide, nationwide and worldwide issues and how they impact society’s health and well-being and the delivery of physical therapy. 10. Providing leadership in the community. 11. Participating in collaborative relationships with other health practitioners and the public at large. 12. Ensuring the blending of social justice and economic efficiency of services.</td>
</tr>
</tbody>
</table>

2. Value-based Behaviors for the Physical Therapist Assistant

For each values-based behavior listed, a definition is provided with sample indicators (not exhaustive) that describe what one would see if the physical therapist assistant were demonstrating that values-based behavior in his or her daily work.

<table>
<thead>
<tr>
<th>Values-Based Behavior With Definition</th>
<th>Sample Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Altruism</strong></td>
<td>1. Providing patient/client-centered interventions.</td>
</tr>
<tr>
<td></td>
<td>2. Readily offering to assist the physical therapist in providing patient/client interventions.</td>
</tr>
<tr>
<td></td>
<td>3. Generously providing the necessary time and effort to meet patient/client needs.</td>
</tr>
<tr>
<td></td>
<td>4. Placing the patient/client’s needs ahead of one’s own, as evidenced by willingness to alter one’s schedule, delay other projects or tasks, etc.</td>
</tr>
<tr>
<td></td>
<td>5. Contributing, as able, to the provision of physical therapy services to underserved and underrepresented populations.</td>
</tr>
<tr>
<td><strong>Caring and Compassion</strong></td>
<td>1. Actively listening to the patient/client and considering the patient/client’s needs and preferences.</td>
</tr>
<tr>
<td></td>
<td>2. Exhibiting compassion, caring, and empathy in providing services to patients/clients.</td>
</tr>
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<td></td>
<td>3. Demonstrating respect for others and considering others as unique and of value.</td>
</tr>
<tr>
<td></td>
<td>4. Considering social, emotional, cultural, psychological, environmental, and economic influences on the patient/client (eg, learning styles, language abilities, cognitive abilities) and adapting approach accordingly.</td>
</tr>
<tr>
<td></td>
<td>5. Recognizing and refraining from acting on one’s social, cultural, gender, and sexual biases; ie, demonstrates a nonjudgmental attitude.</td>
</tr>
<tr>
<td><strong>Continuing Competence</strong></td>
<td>1. Identifying strengths and limitations in knowledge, skills, and behaviors through self-assessment and feedback from physical therapists and others, and developing and implementing strategies to address the limitations.</td>
</tr>
<tr>
<td></td>
<td>2. Maintaining continuing competence using a variety of lifelong learning strategies (eg, continuing education, reflective journals, journal clubs, working with a mentor).</td>
</tr>
<tr>
<td></td>
<td>3. Seeking further education in the use and delivery of interventions based on new evidence as it becomes available.</td>
</tr>
<tr>
<td></td>
<td>4. Developing and implementing a career advancement plan based on interests, opportunities, and career aspirations.</td>
</tr>
<tr>
<td><strong>Duty</strong></td>
<td>1. Demonstrating behaviors, conduct, actions, attitudes, and values consistent with the roles, responsibilities, and tasks of the PTA.</td>
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<tr>
<td></td>
<td>2. Facilitating each patient/client’s achievement of goals for function, health, and wellness, as directed in the plan of care.</td>
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<td></td>
<td>3. Preserving the safety, security, and confidentiality of individuals in all patient/client contexts.</td>
</tr>
<tr>
<td></td>
<td>4. Participating in quality assurance/quality improvement activities in physical therapy care.</td>
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<td></td>
<td>5. Promoting the profession of physical therapy.</td>
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<tr>
<td></td>
<td>6. Providing student instruction and mentoring other PTAs.</td>
</tr>
<tr>
<td>Values-Based Behavior With Definition</td>
<td>Sample Indicators</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Integrity</strong></td>
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</tbody>
</table>
| Integrity is the steadfast adherence to high ethical principles or standards; truthfulness, fairness, doing what you say you will do, and “speaking forth” about why you do what you do. | 1. Adhering to applicable laws regarding scope of work, payment policies and guidelines, institutional policies and procedures, and APTA policies, positions, and guidelines to ensure optimal patient/client care and fiscal management.  
2. Adhering to the highest standards of the profession for the PTA, including the Standards of Ethical Conduct for the Physical Therapist Assistant, Guide for Conduct of the Physical Therapist Assistant, state practice acts, and payment requirements.  
3. Demonstrating the ideals of the values-based behaviors of the PTA.  
4. Demonstrating honesty and trustworthiness in all interactions and relationships.  
5. Choosing employment situations that are congruent with ethical principles and work standards.  
6. Identifying ethical and legal concerns and initiating actions to address the concern, when appropriate. |
| **PT/PTA Collaboration**              |                   |
| The PT/PTA team works together, within each partner’s respective role, to achieve optimal patient/client care and to enhance the overall delivery of physical therapy services. | 1. Educating the PT as needed about the roles, responsibilities, and appropriate utilization of the PTA in the PT/PTA team using available resources (eg, state licensure/practice rules and regulations, PTA clinical problem-solving algorithm, PTA direction and supervision algorithms, Minimum Required Skills of Physical Therapist Assistant Graduates at Entry-Level).  
2. Promoting a positive working relationship within the PT/PTA team.  
3. Demonstrating respect for the roles and contributions of both the PT and PTA in achieving optimal patient/client care, including the PT’s responsibility for the PTA’s performance in patient/client interventions.  
4. Seeking out opportunities to collaborate with the PT to improve outcomes in patient/client care.  
5. Working with the PT in educating consumers and other health care providers about physical therapy. |
| **Responsibility**                    |                   |
| Responsibility is the active acceptance of the roles, obligations, and actions of the PTA, including behaviors that positively influence patient/client outcomes, the profession, and the health needs of society. | 1. Identifying strengths and limitations in knowledge and skill, and working within limitations of personal ability.  
2. Completing patient/client care and other tasks in a timely and efficient manner.  
3. Identifying, acknowledging, and accepting responsibility for actions and, when errors occur, following error reporting processes.  
4. Communicating in a timely manner with others (eg, PTs, patients/clients, and others). |
### Social Responsibility

Social responsibility is the promotion of a mutual trust between the PTA, as a member of the profession, and the larger public that necessitates responding to societal needs for health and wellness.

<table>
<thead>
<tr>
<th>Sample Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Advocating for patient/client needs in the clinical setting.</td>
</tr>
<tr>
<td>2. Demonstrating behaviors that positively represent the profession to the public.</td>
</tr>
<tr>
<td>3. Promoting a healthy lifestyle, wellness, and injury prevention strategies in the community.</td>
</tr>
<tr>
<td>4. Serving the profession and the community, including activities occurring in conjunction with work or outside of work (eg, community health fairs, National Physical Therapy Month events, APTA service).</td>
</tr>
<tr>
<td>5. Advocating for changes in laws, regulations, standards, and guidelines that positively affect physical therapy and patient/client services.</td>
</tr>
</tbody>
</table>

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3. **APTA position on Mentoring of Professionalism in Academic and Clinical Education (HOD 06-03-29-27)**

   “It is the position of the American Physical Therapy Association that:

   It is the responsibility of all academic and clinical faculty, clinical instructors, and professional mentors to actively promote to physical therapist students the importance of professionalism as a critical component of a doctoring profession. Professionalism requires ongoing membership and active participation in the American Physical Therapy Association (APTA) and support of its policies, positions, guidelines, standards, and Code of Ethics. Academic and clinical faculty, clinical instructors, and mentors of physical therapist assistant students shall promote behaviors that are consistent with APTA’s policies, positions, guidelines, standards, and the Standards of Ethical Conduct for the Physical Therapist Assistant, and that support the importance of ongoing membership and active participation in the APTA.”

4. **Code of Ethics for the Physical Therapist (HOD S06-09-07-12)**
   
   Full text at: http://www.apta.org/Ethics/Core

5. **Ethics and Judicial Committee. APTA Guide for Professional Conduct**
   
   Full text at: http://www.apta.org/Ethics/Core

6. **Ethics and Judicial Committee. APTA Guide for Conduct of the Physical Therapist Assistant**
   
   Full text at: http://www.apta.org/Ethics/Core

   
   Full text at: http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/BOD/Practice/PrinciplesofProfessionalism.pdf
H. APTA Guidelines for Clinical Instructors (pages 17-29)


Summary:
Directions for Use

1. Voluntary APTA Guidelines for Clinical Instructors (CIs)
   a. The CI demonstrates clinical competence and legal and ethical behavior that meets or exceeds the expectations of members of the profession of physical therapy.
   b. The CI demonstrates effective communication skills.
   c. The CI demonstrates effective behavior, conduct, and skill in interpersonal relationships.
   d. The CI demonstrates effective instructional skills.
   e. The CI demonstrates effective supervisory skills.
   f. The CI demonstrates performance evaluation skills.

2. APTA Self-Assessments for CIs
   The self-assessment tool, based on the Clinical Instructor Guidelines, allow the participant to self-assess his or her readiness and ongoing performance as a clinical instructor and mentor across the 6 areas.

3. Glossary of Terms
   The glossary of terms is provided to ensure that participants are using language that is consistent throughout the profession.

APTA has valuable information to assist PTs and PTAs in their roles as clinical educators. These tools are to help you assess your readiness and skills as a clinical instructor or a center coordinator of clinical education and are provided to APTA members at no cost and to nonmembers for a cost. Please visit www.apta.org to access the *Guidelines and Self-Assessments for Clinical Education* and the *Center Coordinators of Clinical Education Reference Manual*.

*Reference Manual for Center Coordinators of Clinical Education*
Available to members: www.apta.org/Educators/Clinical/EducatorDevelopment/
Available to nonmembers (E-61) from the APTA Bookstore: www.apta.org/store/

*Guidelines and Self-Assessments for Clinical Education*
Available to members: www.apta.org/Educators/Clinical/SiteDevelopment/
Available to nonmembers (E-48) from the APTA Bookstore: www.apta.org/store/
GUIDELINES AND SELF-ASSESSMENTS FOR CLINICAL EDUCATION DIRECTIONS FOR USE

This resource document should be used to guide the development and enhancement of clinical education sites and to clarify the roles, responsibilities, and expectations of CIs and CCCEs. There are 17 guidelines for clinical education sites and 6 guidelines for CIs and for CCCEs. Below each guideline are statements that clarify the intent, scope, and meaning of the guideline. These guidelines should be used by practice facilities to help determine their readiness to become a clinical education site, and by clinicians to help determine their readiness to become a CI or CCCE.

Following each set of guidelines is a companion self-assessment tool. Response options on the self-assessment forms include yes, no, or developing boxes. The user should check only one box for each item. A yes response indicates that the assessor demonstrates the item, a no response indicates that the assessor has not demonstrated the item, and a developing response indicates that this is an item that is in progress and that the assessor is working toward a yes response. When either a no or developing box is checked, the Comments/Plan section should be completed by briefly describing the actions to be taken to demonstrate the item(s). It is plausible that in some situations a no response could be checked because a particular item may not be relevant for the specific practice setting. Self-assessments for clinical education sites, CCCEs, and CIs may be separated and used in conjunction with their respective set of guidelines. They are most effective, however, when used as a comprehensive document for evaluating the effectiveness of the clinical education site's program and its clinical teachers.

To provide clarity, the terms academic program, clinical education site, and provider of physical therapy are used consistently throughout the documents. Academic program is used to describe that part of the curriculum that occurs at the academic institution of higher education. Clinical education site indicates the entire clinical facility. Provider of physical therapy indicates that part of the clinical education experience that is managed and delivered exclusively under the direction and supervision of the physical therapist with the ability to direct and supervise the physical therapist assistant in providing physical therapy interventions. An asterisk indicates that the word can be found in the glossary. Users of this document are strongly encouraged to refer to the glossary because some commonly used terms may now have different meanings or intent. In addition, the plural form of "students" is used throughout the document to encourage clinical education sites to provide clinical learning experiences to more than one student simultaneously, using alternative collaborative and cooperative approaches to student supervision where feasible.

Opportunities should be provided for CIs and CCCEs to discuss the guidelines and self-assessments to determine how they should be applied to their specific clinical setting and how they may be used to determine an individual's readiness to become a CI or CCCE. In addition, academic programs should consider using information from the clinical educators' completed self-assessments to help in the development of the clinical site and the clinical educators. Based on this information, academic programs can ensure high-quality clinical learning experiences for their students by providing in-service and continuing education programs that will enhance the overall clinical education site* and will help CIs and CCCEs keep up-to-date on current practice.

GUIDELINES FOR CLINICAL INSTRUCTORS

1.0 THE CLINICAL INSTRUCTOR (CI) DEMONSTRATES CLINICAL COMPETENCE, AND LEGAL AND ETHICAL BEHAVIOR THAT MEETS OR EXCEEDS THE EXPECTATIONS OF MEMBERS OF THE PROFESSION OF PHYSICAL THERAPY.

1.1 One year of clinical experience is preferred as minimal criteria for serving as the CI. Individuals should also be evaluated on their abilities to perform CI responsibilities.

1.1.1 The CI demonstrates a desire to work with students by pursuing learning experiences to develop knowledge and skills in clinical teaching.
1.2 The CI is a competent physical therapist or physical therapist assistant.

1.2.1 The CI demonstrates a systematic approach to patient/client care using the patient/client management model describe in the *Guide to Physical Therapist Practice*.

1.2.2 The CI uses critical thinking in the delivery of health services.

1.2.3 Rationale and evidence is provided by:

1.2.3.1 The physical therapist for examination, evaluation, diagnosis, prognosis, interventions, outcomes, and reexaminations.

1.2.3.2 The physical therapist assistant for directed interventions, data collection associated with directed interventions, and outcomes.

1.2.4 The CI demonstrates effective time-management skills.

1.2.5 The CI demonstrates the core values (accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility) associated with professionalism in physical therapy.

1.3 The CI adheres to legal practice standards.

1.3.1 The CI holds a valid license, registration, or certification as required by the state in which the individual provides physical therapy services.

1.3.2 The CI provides physical therapy services that are consistent with the respective state/jurisdictional practice act and interpretive rules and regulations.

1.3.3 The CI provides physical therapy services that are consistent with state and federal legislation, including, but not limited to, equal opportunity and affirmative action policies, HIPAA, Medicare regulations regarding reimbursement for patient/client care where students are involved, and the ADA.

1.3.3.1 The physical therapist is solely responsible for ensuring the patient/client is aware of the student status of any student involved in providing physical therapy services.

1.4 The CI demonstrates ethical behavior.

1.4.1 The CI provides physical therapy services ethically as outlined by the clinical education site policy and the *APTA Code of Ethics, Standards of Ethical Conduct for the Physical Therapist Assistant, Guide for Professional Conduct, Guide for Conduct of the Affiliate Member*, and *Guide to Physical Therapist Practice*.

2.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE COMMUNICATION SKILLS.

2.1 The CI uses verbal, nonverbal, and written communication skills and information technology to clearly express himself or herself to students and others.

2.1.1 The CI defines performance expectations for students.

2.1.2 The CI and student(s) collaborate to develop mutually agreed-on goals and objectives for the clinical education experience.

2.1.3 The CI provides feedback to students.

2.1.4 The CI demonstrates skill in active listening.

2.1.5 The CI provides clear and concise communication.

2.2 The CI is responsible for facilitating communication.

2.2.1 The CI encourages dialogue with students.

2.2.2 The CI provides time and a place for ongoing dialogue to occur.

2.2.3 The CI initiates communication that may be difficult or confrontational.

2.2.4 The CI is open to and encourages feedback from students, clinical educators, and other colleagues.

3.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE BEHAVIOR, CONDUCT, AND SKILL IN INTERPERSONAL RELATIONSHIPS.

3.1 The CI forms a collegial relationship with students.

3.1.1 The CI models behaviors and conduct, and instructional and supervisory skills that are expected of the physi-
3.1.2 The CI promotes the student as a colleague to others.

3.1.3 The CI demonstrates cultural competence with respect for and sensitivity to individual and cultural differences.

3.1.4 The CI is willing to share his or her strengths and weaknesses with students.

3.2 The CI is approachable by students.

3.2.1 The CI assesses and responds to student concerns with empathy, support, or interpretation, as appropriate.

3.3 The CI interacts with patients/clients, colleagues, and other health care providers to achieve identified goals.

3.4 The CI represents the physical therapy profession positively by assuming responsibility for career and self-development and demonstrates this responsibility to the students.

3.4.1 Activities for development may include, but are not limited to, continuing education courses, journal clubs, case conferences, case studies, literature review, facility sponsored courses, post–professional/entry-level education, area consortia programs, and active involvement in professional associations, including APTA.

4.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE INSTRUCTIONAL SKILLS.

4.1 The CI collaborates with students to plan learning experiences.

4.1.1 Based on a plan, the CI implements, facilitates, and evaluates learning experiences with students.

4.1.2 Learning experiences should include both patient/client interventions and patient/client practice management activities.

4.2 The CI demonstrates knowledge of the student’s academic curriculum, level of didactic preparation, current level of performance, and the goals of the clinical education experience.

4.3 The CI recognizes and uses the entire clinical environment for potential learning experiences, both planned and unplanned.

4.4 The CI integrates knowledge of various learning styles to implement strategies that accommodate students’ needs.

4.5 The CI sequences learning experiences to promote progression of the students’ personal and educational goals.

4.5.1 The CI monitors and modifies learning experiences in a timely manner based on the quality of the student’s performance.

5.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE SUPERVisory SKILLS.

5.1 The CI supervises the student in the clinical environment by clarifying goals, objectives, and expectations.

5.1.1 The CI presents clear performance expectations to students at the beginning and throughout the learning experience.

5.1.2 Goals and objectives are mutually agreed on by the CI and student(s).

5.2 Feedback is provided both formally and informally.

5.2.1 To provide student feedback, the CI collects information through direct observation and discussion with students, review of the students’ patient/client documentation, available observations made by others, and students’ self-assessments.

5.2.2 The CI provides frequent, positive, constructive, and timely feedback.

5.2.3 The CI and students review and analyze feedback regularly and adjust the learning experiences accordingly.

5.3 The CI performs constructive and cumulative evaluations of the students’ performance.

5.3.1 The CI and students both participate in ongoing formative evaluation.

5.3.2 Cumulative evaluations are provided at least at midterm and at the completion of the clinical education experience and include student self-assessments.
6.0 THE CLINICAL INSTRUCTOR DEMONSTRATES PERFORMANCE EVALUATION SKILLS.

6.1 The CI articulates observations of students’ knowledge, skills, and behavior as related to specific student performance criteria.

6.1.1 The CI familiarizes herself or himself with the student’s evaluation instrument prior to the clinical education experience.

6.1.2 The CI recognizes and documents students’ progress, identifies areas of entry-level competence, areas of distinction, and specific areas of performance that are unsafe, ineffective, or deficient in quality.

6.1.3 Based on areas of distinction, the CI plans, in collaboration with the CCCE and the ACCE/DCE when applicable, activities that continue to challenge students’ performance.

6.1.4 Based on the areas identified as inadequate, the CI plans, in collaboration with the CCCE and ACCE/DCE when applicable, remedial activities to address specific deficits in student performance.

6.2 The CI demonstrates awareness of the relationship between the academic program and clinical education site concerning student performance evaluations, grading, remedial activities, and due process in the case of student failure.

6.3 The CI demonstrates a constructive approach to student performance evaluation that is educational, objective, and reflective and engages students in self-assessment (e.g., problem identification, processing, and solving) as part of the performance evaluation process.

6.4 The CI fosters student evaluations of the clinical education experience, including learning opportunities, CI and CCCE performance, and the evaluation process.

The foundation for this document is:


Revisions of this document are based on:


## SELF-ASSESSMENTS FOR CLINICAL INSTRUCTORS

### 1.0 THE CLINICAL INSTRUCTOR (CI) DEMONSTRATES CLINICAL COMPETENCE AND LEGAL AND ETHICAL BEHAVIOR THAT MEETS OR EXCEEDS THE EXPECTATIONS OF MEMBERS OF THE PROFESSION OF PHYSICAL THERAPY.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Developing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you, as the clinical instructor (CI), have at least 1 year of clinical experience?</td>
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<tr>
<td>2. Do you demonstrate a desire to work with students by pursuing learning experiences to develop knowledge and skills in clinical teaching?</td>
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<tr>
<td>3. Do you, as the CI, demonstrate competence as a physical therapist or a physical therapist assistant by:</td>
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<tr>
<td>a) Utilizing the patient/client management model in the <em>Guide to Physical Therapist Practice</em> to demonstrate a systematic approach to patient care?</td>
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<tr>
<td>b) Using clinical reasoning and evidence-based practice in the delivery of health services?</td>
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<tr>
<td>c) Providing rationale for the patient/client?</td>
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<tr>
<td>▪ Examination, evaluation, diagnosis, prognosis, interventions, outcomes, and reexaminations (PT)</td>
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<td>▪ Interventions (including data collection and outcomes associated with those interventions) as directed and supervised by the PT and within the plan of care (PTA)</td>
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<td>d) Demonstrating effective time-management skills?</td>
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<tr>
<td>4. Do you, as the CI, adhere to legal practice standards?</td>
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<tr>
<td>a) By holding a current license/registration/certification as required by the physical therapy practice act in the state in which you practice?</td>
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<tr>
<td>b) By providing physical therapy services that are consistent with your state practice act and interpretive rules and regulations?</td>
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<tr>
<td>c) By providing physical therapy services that are consistent with state and federal legislation, including, but not limited to:</td>
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<td></td>
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<tr>
<td>▪ Equal opportunity and affirmative action policies</td>
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<tr>
<td>▪ Americans With Disabilities Act (ADA)</td>
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<tr>
<td>d) By ensuring that the patients/clients have been informed of and consent to have a student involved in providing physical therapy services?</td>
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<tr>
<td>5. Do you, as the CI, demonstrate ethical behavior, as outlined by the clinical education site policy and the APTA <em>Code of Ethics and Guide for Professional Conduct</em>?</td>
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<tr>
<td>6. Do you, as the CI, consistently demonstrate the APTA Core Values (<a href="http://www.apta.org/documents/public/education/professionalism.pdf">www.apta.org/documents/public/education/professionalism.pdf</a>) of accountability,* altruism,* compassion/caring,* excellence,* integrity,* professional duty,* and social responsibility*?</td>
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</table>

**COMMENTS/PLAN:**
### 2.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE COMMUNICATION SKILLS.

1. Do you, as the CI, use verbal, nonverbal, and written communication skills and information technology to clearly express yourself to students to:
   - a) Define performance expectations for students? □ Yes □ No □ Developing
   - b) Collaborate to develop mutually agreed-on goals and objectives for the clinical education experience? □ Yes □ No □ Developing
   - c) Provide feedback? □ Yes □ No □ Developing
   - d) Demonstrate skill in active listening? □ Yes □ No □ Developing

2. Do you, as the CI, facilitate communication by:
   - a) Encouraging dialogue with students? □ Yes □ No □ Developing
   - b) Providing time and a place for ongoing dialogue to occur? □ Yes □ No □ Developing
   - c) Initiating communication that may be difficult or confrontational around an issue of concern? □ Yes □ No □ Developing
   - d) Remaining open to and encouraging feedback from students, clinical educators, and other colleagues? □ Yes □ No □ Developing

### COMMENTS/PLAN:

### 3.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE BEHAVIOR, CONDUCT, AND SKILL IN INTERPERSONAL RELATIONSHIPS.

1. Do you, as the CI, form a collegial relationship with students? □ Yes □ No □ Developing
2. Do you model behaviors and conduct and instructional and supervisory skills that are expected of the PT or PTA? □ Yes □ No □ Developing
3. Do you demonstrate an understanding of the impact of your behavior and conduct as a role model for students? □ Yes □ No □ Developing
4. Do you promote the student as a colleague to others? □ Yes □ No □ Developing
5. Do you demonstrate respect for and sensitivity to individual differences? □ Yes □ No □ Developing
6. Are you willing to share your strengths and weaknesses with students? □ Yes □ No □ Developing
7. Do you, as the CI, remain approachable by assessing and responding to student concerns with empathy, support, or interpretation, as appropriate? □ Yes □ No □ Developing
8. Do you, as the CI, interact appropriately with patients, colleagues, and other health professionals to achieve identified goals? □ Yes □ No □ Developing
1. Do you represent the physical therapy profession positively by assuming responsibility for career and self-development and demonstrate this responsibility to the student by participation in activities, such as:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Developing</th>
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<tbody>
<tr>
<td>a) Continuing education courses?</td>
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<tr>
<td>b) Journal club?</td>
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<tr>
<td>c) Case conferences?</td>
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<tr>
<td>d) Case studies?</td>
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<tr>
<td>e) Literature review?</td>
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<td>f) Facility sponsored courses?</td>
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<tr>
<td>g) Post-entry-level education?</td>
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<td>h) Area consortia programs?</td>
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<tr>
<td>i) Membership and active involvement in the profession (eg, America Physical Therapy Association)</td>
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</tbody>
</table>

**COMMENTS/PLAN:**

### 4.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE INSTRUCTIONAL SKILLS.

1. Do you, as the CI, implement, facilitate, and evaluate learning experiences for students based on a plan created in collaboration with students? [Yes] [No] [Developing]

2. Do you, as the CI, review the student’s academic curriculum, level of didactic preparation, current level of performance, and the goals of the clinical education experience? [Yes] [No] [Developing]

3. Do you include learning experiences in the patient/client management model (eg, examination, evaluation, diagnosis, prognosis, plan of care, intervention, and outcomes for the PT student; directed interventions with the plan of care for the PTA student) and practice management activities (eg, billing, staff meetings, marketing)? [Yes] [No] [Developing]

4. Do you, as the CI, maximize learning opportunities by using planned and unplanned experiences within the entire clinical environment? [Yes] [No] [Developing]

5. Do you, as the CI, integrate knowledge of various learning styles to implement strategies that accommodate students’ needs? [Yes] [No] [Developing]

6. Do you, as the CI, sequence learning experiences to allow progression towards the student’s personal and educational goals? [Yes] [No] [Developing]

7. Do you, as the CI, monitor and modify experiences in a timely manner, based on the quality of the student's performance? [Yes] [No] [Developing]

**COMMENTS/PLAN:**
### 5.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE SUPERVISORY SKILLS.

<table>
<thead>
<tr>
<th>1. Do you, as the CI, present clear performance expectations to students at the beginning of and throughout the learning experience?</th>
<th>□ Yes □ No □ Developing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Are goals and objectives mutually agreed on by you and students?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
<tr>
<td>3. Do you, as the CI, provide both formal and informal feedback?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
<tr>
<td>4. To provide student feedback, do you collect information through:</td>
<td></td>
</tr>
<tr>
<td>a) Direct observation and discussions with students?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
<tr>
<td>b) Review of the students' patient/client documentation?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
<tr>
<td>c) Available observations made by others?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
<tr>
<td>d) Students' self-assessments?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
<tr>
<td>5. Do you, as the CI, provide feedback to students that is:</td>
<td></td>
</tr>
<tr>
<td>a) Frequent?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
<tr>
<td>b) Positive?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
<tr>
<td>c) Constructive?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
<tr>
<td>d) Timely?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
<tr>
<td>6. Do you, as the CI, review and analyze feedback regularly and adjust learning experiences accordingly?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
<tr>
<td>7. Do you, as the CI, perform constructive (interim) and cumulative (final) evaluations of the students' performance by:</td>
<td></td>
</tr>
<tr>
<td>a) Participating with the student in ongoing constructive evaluations?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
<tr>
<td>b) Providing cumulative evaluations at least at midterm and at the completion of the clinical education experience?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
<tr>
<td>c) Including student self-assessments?</td>
<td>□ Yes □ No □ Developing</td>
</tr>
</tbody>
</table>

**COMMENTS/PLAN:**
## 6.0 THE CLINICAL INSTRUCTOR DEMONSTRATES PERFORMANCE EVALUATION SKILLS

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Do you, as the CI, familiarize yourself with the students’ evaluation instrument(s) prior to the clinical education experience?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2.</td>
<td>Do you, as the CI, use and articulate available information and observations when evaluating students’ knowledge, skills, and behavior as related to specific performance criteria?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3.</td>
<td>Do you, as the CI, recognize and document students’ progress by identifying areas of:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>a)</td>
<td>Entry-level competence?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>b)</td>
<td>Exceptional performance?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>c)</td>
<td>Unsafe or ineffective performance?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>d)</td>
<td>Appropriate progression?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4.</td>
<td>In collaboration with the CCCE and ACCE/DCE, do you plan activities that continue to challenge student performance based on areas of:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>a)</td>
<td>Exceptional performance?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>b)</td>
<td>Appropriate progression?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>c)</td>
<td>Specific deficits?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5.</td>
<td>Do you, as the CI, demonstrate awareness of the relationship between the academic program and clinical education site as it relates to:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>a)</td>
<td>Student performance evaluations?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>b)</td>
<td>Grading?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>c)</td>
<td>Remedial activities?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>d)</td>
<td>Due process in the case of student failure?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6.</td>
<td>Do you, as the CI, demonstrate a constructive approach to student performance evaluation that is:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>a)</td>
<td>Educational?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>b)</td>
<td>Objective?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>c)</td>
<td>Reflective?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>d)</td>
<td>Directed at engaging students in self-assessment?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7.</td>
<td>Do you foster student evaluation of the clinical education experience, including:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>a)</td>
<td>Learning opportunities?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>b)</td>
<td>CI performance?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>c)</td>
<td>CCCE performance?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>d)</td>
<td>The evaluation process?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**COMMENTS/PLAN:**
GLOSSARY

Academic Coordinator/Director of Clinical Education (ACCE/DCE): An individual who is responsible for managing and coordinating the clinical education program at the academic institution, including facilitating development of the clinical education site and clinical educators. This person is also responsible for coordinating student placements, communicating with clinical educators about the academic program and student performance, and maintaining current information on clinical education sites.

Academic program: That aspect of the curriculum where students’ learning occur directly as a function of being immersed in the academic institution of higher education; the didactic component of the curriculum that is managed and controlled by the physical therapy education program.

Accountability: Active acceptance of responsibility for the diverse roles, obligations, and actions of the physical therapist including self-regulation and other behaviors that positively influence patient/client outcomes, the profession, and the health needs of society. (Professionalism in Physical Therapy: Core Values; August 2003.)

ADA (Americans with Disabilities Act): The 1990 federal statute that prohibits discrimination against individuals in employment, public accommodations, etc.

Administration: The skilled process of planning, directing, organizing, and managing human, technical, environmental, and financial resources effectively and efficiently. A physical therapist or physical therapist assistant can perform administrative activities, based on recognition of additional formal and informal training, certification, or education.

Affective: Relating to the expression of emotion (eg, affective behavior).

Altruism: The primary regard for or devotion to the interest of patients/clients, thus assuming the fiduciary responsibility of placing the needs of the patient/client ahead of the physical therapist’s self interest. (Professionalism in Physical Therapy: Core Values; August 2003.)

Caring: The concern, empathy, and consideration for the needs and values of others. (Professionalism in Physical Therapy: Core Values, August 2003.)

Center Coordinator of Clinical Education (CCCE): Individual(s) who administer, manage, and coordinate clinical instructor assignments and learning activities for students during their clinical education experiences. In addition, this person determines the readiness of persons to serve as clinical instructors for students, supervises clinical instructors in the delivery of clinical education experiences, communicates with the academic program regarding student performance, and provides essential information about the clinical education program to physical therapy programs.

Clients: Individuals who are not necessarily sick or injured but can benefit from a physical therapist’s consultation, professional advice, or services. Clients are also businesses, school systems, families, caregivers, and others who benefit from physical therapy services.

Clinical education agreement: A legal contract that is negotiated between academic institutions and clinical education sites that specifies each party’s roles, responsibilities, and liabilities relating to student clinical education. (Synonyms: letter of agreement, affiliation contract)

Clinical education consortia: The formation of regional groups that may include physical therapy programs or clinical educators for the express purpose of sharing resources, ideas, and efforts.

Clinical education experience: That aspect of the curriculum where students’ learning occurs directly as a function of being immersed within physical therapy practice. These dynamic and progressive experiences comprise all of the direct and indirect formal and practical “real life “ learning experiences provided for students to apply classroom knowledge, skills, and behaviors in the clinical environment. These experiences can be of short or long duration (eg, part-time and full-time experiences, internships that are most often full-time postgraduation experiences for a period of 1 year) and can vary by the manner in which the learning experiences are provided (eg, rotations on different units that vary within the same setting, rotations between different practice settings within the same health care system). These experiences include comprehensive care of patients across the life span and related activities. (Synonym: Clinical learning experiences)

Clinical education program: That portion of a physical therapy program that is conducted in the health care environment rather than the academic environment; the sum of all clinical education experiences provided.
Clinical education site: The physical therapy practice environment where clinical education occurs; that aspect of the clinical education experience that is managed and delivered exclusively within the physical therapy practice environment and encompasses the entire clinical facility.

Clinical instructor (CI): An individual at the clinical education site, who directly instructs and supervises students during their clinical learning experiences. These individuals are responsible for carrying out clinical learning experiences and assessing students' performance in cognitive,* psychomotor,* and affective domains as related to entry-level clinical practice and academic and clinical performance expectations. (Synonyms: clinical teacher; clinical tutor; clinical supervisor)

Clinical Performance Instrument (CPI): American Physical Therapy Association developed student evaluation instruments that are used to assess the clinical education performance of physical therapist and physical therapist assistant students. The Physical Therapist CPI: Version 2006 consists of 18 performance criteria and the Physical Therapist Assistant CPI: Version 2009 consists of 14 performance criteria.

Cognitive: Characterized by knowledge, awareness, reasoning, and judgment.

Communication: A verbal or nonverbal exchange between two or more individuals or groups that is: open and honest; accurate and complete; timely and ongoing; and occurs between physical therapists and physical therapist assistants, as well as between, patients, family or caregivers, health care providers, and the health care delivery system.

Compassion: The desire to identify with or sense something of another's experience; a precursor of caring. (Professionalism in Physical Therapy: Core Values; August 2003.)

Competent: Demonstrates skill and proficiency in a fluid and coordinated manner in rendering physical therapy care (physical therapist), or those aspects of physical therapy care (eg, interventions) as directed and supervised by the physical therapist (physical therapist assistant).

Competencies: A set of standard criteria, determined by practice setting and scope, by which one is objectively evaluated.

Cultural competence: Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. “Culture” refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. “Competence” implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Working definition adapted from Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda, Office of Minority Health, Public Health Service, US Department of Health and Human Services; 1999.

Cultural and individual differences: The recognition and respect for and response to, age, gender, race, creed, national and ethnic origin, sexual orientation, marital status, health status, disability or limitations, socioeconomic status, and language.

Data collection: For the physical therapist assistant, this term is used in the context of providing interventions that are directed by the physical therapist and within the plan of care and consist of processes or procedures used to collect information relative to the intervention, which may include observation, measurement, and subjective, objective, and functional findings.

Diagnosis: Diagnosis is both a process and a label. The diagnostic process performed by the physical therapist includes integrating and evaluating data that are obtained during the examination to describe the patient/client condition in terms that will guide the prognosis, the plan of care, and intervention strategies. Physical therapists use diagnostic labels that identify the impact of a condition on function at the level of the system (especially the movement system) and at the level of the whole person. (Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.)

Ethical and legal behaviors: Those behaviors that result from a deliberate decision-making process that adheres to an established set of standards for conduct that are derived from values that have been mutually agreed on and adopted for that group.

Excellence: Excellence is physical therapy practice that consistently uses current knowledge and theory while understanding personal limits, integrates judgment and the patient/client perspective, embraces advancement, challenges mediocrity, and works toward development of new knowledge. (Professionalism in Physical Therapy: Core Values; August 2003.)

Evaluation: A dynamic process in which the physical therapist makes clinical judgments based on data gathered during the examination. No defined number or range of number of visits is established for this type of episode. (Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.)
Examination: A comprehensive and specific testing process performed by a physical therapist that leads to diagnostic classification or, as appropriate, to a referral to another practitioner. The examination has three components: the patient/client history, the systems reviews, and tests and measures. *Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.*

Integrity: Steadfast adherence to high ethical principles or professional standards; truthfulness, fairness, doing what you say you will do, and “speaking forth” about why you do what you do. *Professionalism in Physical Therapy: Core Values; August 2003.*

Intervention: The purposeful and skilled interaction of the physical therapist with the patient/client and, when appropriate, with other individuals involved in care (ie, physical therapist assistant), using various methods and techniques to produce changes in the condition. *Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.*

Outcomes (assessment of the individual): Performed by the physical therapist and is a measure (or measures) of the intended results of patient/client management, including changes in impairments, functional limitations, and disabilities and the changes in health, wellness, and fitness needs that are expected as the results of implementing the plan of care. The expected outcomes in the plan should be measurable and time limited.

Patients: Individuals who are the recipients of physical therapy direct intervention.


Philosophy: Broad context and theoretical framework provided for program purpose, organization, structure, goals, and objectives; a statement of philosophy under some conditions may be synonymous with a mission statement.

Physical therapist: A person who is a graduate of an accredited physical therapist education program and is licensed to practice physical therapy.

Physical therapist assistant: A person who is a graduate of an accredited physical therapist assistant program and who assists the physical therapist in the provision of physical therapy. The physical therapist assistant may perform physical therapy procedures and related tasks that have been selected and delegated by the supervising physical therapist.

Physical therapist professional education: First level of education that prepares student to enter the practice of physical therapy.

Physical therapy: Use of this term encompasses both physical therapists and physical therapist assistants.

Physical therapy personnel: This includes all persons who are associated with the provision of physical therapy services, including physical therapists, physical therapist assistants who work under the direction and supervision of a physical therapist, and other support personnel. (Synonym: physical therapy staff)

Plan of care: Statements that specify the anticipated goals and the expected outcomes, predicted level of optimal improvement, specific interventions to be used, and proposed duration and frequency of the interventions that are required to reach the goals and outcomes. The plan of care includes the anticipated discharge plans. *Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.*

Professional: A person who is educated to the level of possessing a unique body of knowledge, adheres to ethical conduct, requires licensure to practice, participates in the monitoring of one’s peers, and is accepted and recognized by the public as being a professional. (See *Physical Therapist.*)

Professional duty: Professional duty is the commitment to meeting one’s obligations to provide effective physical therapy services to individual patients/clients, to serve the profession, and to positively influence the health of society. *Professionalism in Physical Therapy: Core Values; August 2003.*


Provider of physical therapy: This indicates the part of the clinical education experience that is managed and delivered exclusively under the direction and supervision of the physical therapist including within the plan of care physical therapy interventions provided by the physical therapist assistant.

Psychomotor: Refers to motor activity that is preceded by or related to mental activity.
Reexamination: The process of performing selected tests and measures after the initial examination to evaluate progress and to modify or redirect interventions. (Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.)

Screening: Determining the need for further examination or consultation by a physical therapist or for referral to another health professional. (Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.) (See also: Cognitive.)

Social responsibility: The promotion of a mutual trust between the physical therapist as a part of the profession and the larger public that necessitates responding to societal needs for health and wellness. (Professionalism in Physical Therapy: Core Values, August 2003.)

Student placement forms: A questionnaire distributed by physical therapy education programs to clinical education sites requesting the number and type of available placements for students to complete clinical education experiences.

Supervision: A process where two or more people actively participate in a joint effort to establish, maintain, and elevate a level of performance; it is structured according to the supervisee's qualifications, position, level of preparation, depth of experience, and the environment in which the supervisee functions.

Treatment: The sum of all interventions provided by the physical therapist to a patient/client during an episode of care. (Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.)

Validity: The degree to which accumulated evidence and theory support specific interpretation of test scores entailed by proposed use of a test. The degree to which a test measures what it is intended to measure; a test is valid for a particular purpose for a particular group.

Variety of clinical education experiences: Considers multiple variables when providing students with clinical learning experiences relative to patient care including, but not limited to, patient acuity, continuum of care, use of a PT/PTA care-delivery team, complexity of patient diagnoses and environment, and health care delivery system.
Activity 3
Self-Assessment

• Take 10 minutes to perform a quick self-assessment of your current skill development as a clinical instructor. This will form the baseline for your current perceived performance and skill.

• Review your self-assessment prior to the beginning of your next student’s clinical education experience. This will serve as a reminder of the types of activities and behaviors that you want to perform as a CI for the student.

• After the completion of the student’s clinical experience, reflect on your performance as a CI based on the clinical instructor guidelines. Consider some of the following questions:
  - What did I do effectively in working with this student?
  - How do I know I was effective?
  - What could I have changed that would have enabled the student to have progressed differently?
  - What feedback did the student provide during the learning experience that was implemented?
  - What feedback did the student provide during the learning experience that was not implemented? Why?

• Through the process of self-reflection, identify 1 or 2 skills that you would like to improve in mentoring and instructing your next student.

• As you continue this process, you will be able to see your growth and development in your performance and role as a clinical instructor and mentor.
REFERENCES


ADDITIONAL RECOMMENDED READINGS


SECTION II
Readiness to Learn
SECTION II
READINESS TO LEARN

Introduction
Section II addresses the student’s readiness to learn. Consideration is given to the principles of adult learning, stages of learning, domains of learning, proper construction of behavioral objective, and influence of learning style on the teaching/learning experience. Opportunities are provided for participants to develop beginning skill in writing and analyzing behavioral objectives.

The corollary to the student’s readiness to learn is the clinical instructor’s readiness to teach. Section III focuses on the instructor's readiness to teach. As you go through this section, begin to consider how you might think about teaching students to learn.

Objectives
After completing Section II, you will be able to:

1. Describe how stages of learning influence the student’s readiness to learn.
2. Write a behavioral objective.
3. Analyze the components and learning domain(s) of a behavioral objective.
4. Identify characteristics of the adult learner.
5. Describe how clinical instruction can be designed to support the development of an adult learner.
6. Relate differences in learning style to individual strengths in problem solving.
7. Incorporate the role of learning style in the teaching/learning experience.
8. Discuss the benefits of developing a flexible learning style.
9. Identify characteristics of the adult learner.

Assumptions
1. Students are able to assume responsibility for their own learning.
2. Individual learning style preferences are a factor in effective learning.
3. Clinical instructors and students should work together to develop flexible teaching and learning styles.
4. Learning is a lifelong process.
A. Basic Principles of Learning

1. There are different levels of learning.

2. There is a basic hierarchical order to learning.

3. Learning at any level builds upon and grows out of learning at different levels.

4. Learning generally occurs from simple to complex.

5. Students move through stages at different rates (depending on skill).

6. Students move through stages at different rates from each other.
B. Stages of Learning

1. Three Stages
   a. Exposure

   b. Acquisition (practice)

   c. Integration (mastery)

2. Parameters
   a. Novice to mature (professional development and socialization; skill in learning)
   b. Dependent to independent (clinical instruction with respect to clinical judgment; ie, willingness to take risks)

3. Student Needs/Abilities Vary by Stage

The Learning Vector Model

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Section II: The Readiness to Learn
C. Clinical Education and Stages of Learning


**Supervision/guidance** refers to the level and extent of assistance required by the student to achieve entry-level performance.

- As a student progresses through clinical education experiences, the degree of supervision/guidance needed is expected to progress from 100% supervision to independent performance with consultation and may vary with the complexity of the patient or environment.

**Quality** refers to the degree of knowledge and skill proficiency demonstrated.

- As a student progresses through clinical education experiences, quality should range from demonstration of limited skill to a skilled or highly skilled performance.

**Complexity** refers to the number of elements that must be considered relative to the patient, task, and/or environment.

- As a student progresses through clinical education experiences, the level of complexity of tasks, patient management, and the environment should increase, with fewer elements being controlled by the CI.

**Consistency** refers to the frequency of occurrences of desired behaviors related to the quality dimension.

- As a student progresses through clinical education experiences, consistency of highly skilled performance is expected to progress from infrequently to routinely.

**Efficiency** refers to the ability to perform in a cost-effective and timely manner.

- As the student progresses through clinical education experiences, efficiency should progress from a high expenditure of time and effort to economical and timely performance.

2. Exposure: Student is a **novice; dependent on CI**.

a. CI must:
   i. set expectations for student
   ii. plan learning activities
   iii. perform demonstrations
   iv. elicit student feedback through questioning
   v. give feedback about ability to answer questions

b. Student must:
   i. answer questions

3. Acquisition: Student can participate in planning and evaluating his/her learning experience.

a. CI must:
   i. give student options in selecting portion of learning experience
   ii. guide student through activity
   iii. give feedback on work
   iv. give feedback on the ability to self-assess

b. Student must:
   i. perform skill
4. Integration: Student can now take responsibility for planning, implementing, and evaluating the learning experience. CI and student work together.
   a. CI must:
      i. act as a consultant
      ii. provide feedback on skill and ability to self-assess
      iii. give feedback on the student’s ability to integrate feedback from other sources
   b. Student must:
      i. perform skill independently
      ii. evaluate own work
      iii. seek feedback from all appropriate sources

D. Definition of Domains

1. Domains of Learning
   These domains describe 3 types of observable behavior and are therefore used to categorize behavioral objectives. The purpose of dividing learning into “domains” is to make it easier to identify the different aspects of the learning process. When planning learning experiences, it is important for the CI to consider how the processes described in each domain will be incorporated into the learning process for that experience.

   **Learning occurs in three primary domains: cognitive, psychomotor, and affective.**
   - If the *intent* of the objective is knowledge and understanding of subject matter, it falls in the **cognitive** domain.
     **Example:** After the lecture, the student will correctly list 3 precautions for patients who have had coronary artery bypass graft surgery (CABG). (cognitive)
   - If the *intent* of the objective is physical action or motor skills, it is in the **psychomotor** domain.
     **Example:** Following a demonstration, the student will safely perform a sliding board transfer for a patient with left hemiparesis. (psychomotor)
   - If the *intent* of the objective involves feelings, attitudes, or values, it falls in the **affective** domain.
     **Example:** During weekly clinical instructor/student meetings, the student will accept formative feedback without defensive behavior. (affective)
2. Taxonomies of Domains\textsuperscript{6,7}

Each domain is divided hierarchically into a series of progressive stages. This hierarchical system is often referred to as taxonomy.

Each stage is further defined by a list of verbs describing what a student should be able to do in order to have mastered that stage.

When a CI is establishing objectives for a student’s learning experience, these verbs are useful in identifying the particular area and skills that need to be completed for the student’s learning process to follow an orderly, stepwise progression.

Examples:

a. During the laboratory session, the student will instruct the lab partner in supine to sit bed mobility while observing the precautions for cardiac arterial bypass graft surgery. (cognitive)

b. Following a demonstration, the student will safely perform a sliding board transfer for a patient with left hemiparesis. (psychomotor)

c. During weekly clinical instructor/student meetings, the student will request formative feedback to improve her clinical skills. (affective)
Activity 3A

Using Domains to Focus Objectives

Scenario 1:
Lucy has wonderful examination and evaluation skills. Her examinations are complete, thorough, appropriate, effective, and efficient. However, at midterm, Lucy is still having difficulty planning effective treatment programs. She wants to manage all patients with low back pain the same, all patients with adhesive capsulitis the same, etc. Each time you provide her with a suggestion, she readily incorporates it into her “standard” treatment for that particular diagnosis.

1. Is Lucy having difficulty with a skill, her attitude, or knowledge?

2. What is her problem?

3. Where on the taxonomy does what you want Lucy to be able to do occur?

4. Where might you start in trying to determine where the learning process has fallen apart for Lucy?

(See answer key in Section VII.)
Activity 3B
Using Domains to Focus Objectives

Scenario 2:
Curt is a PT student on his final clinical experience in an inpatient pediatric rehabilitation unit. He is meeting your expectations within the patient/client management model in the areas of examination, evaluation, and interventions. He is very eager to expand his knowledge base and frequently collaborates with other PT staff members for ideas. Your concern at this point is his limited participation in team meetings. He frequently interrupts other team members and does not seem to listen to their opinions. On occasion, he has also missed meetings entirely. When asked why, he responds that he needed time to plan for a patient and could “catch up” with other team members at any time during the day if he wanted their input.

1. Is Curt having difficulty with a skill, his attitude, or knowledge?

2. What is the problem?

3. Where on the taxonomy does what you want Curt to be able to do occur?

4. Where might you start in trying to determine where the learning process has fallen apart for Curt?

(See answer key in Section VII.)
E. Writing Behavioral Objectives

1. An Overview

“The most basic step in the development of any aspect of clinical education is the determination of objectives. The literature is virtually unanimous in its emphasis on the importance of developing objectives as a basis for planning.

“Many authors favor the use of objectives written in behavioral terms. These should describe the learner’s behavior at the end of the learning. (What the learner is capable of or can do), the conditions under which the learner must function, and the evaluation method that will be used to assess the learning.

“In that format, the exact meaning of an objective can be clear and thus more helpful to an instructor in planning and evaluating a program and to a student in knowing where he/she is, and what to expect in the experience...

“...Objectives for clinical education (desired outcomes) have several purposes. First, they can be utilized in designing and developing the clinical education program. Only after the desired outcomes are known can a program be designed to produce those outcomes. Second, developing objectives can help determine the teaching methods to be used. Only by knowing the objectives of the experience can the CI determine whether the student should observe, practice, discuss, or write something. Third, developing objectives can assess both the learning experience itself and the student’s achievement of the objective. A fringe benefit to the development of objectives is the upgrding of the abilities of the developers. The increase in capability and commitment of persons who have been involved in the development of programs, including the development of objectives, has been documented by several sources and is certainly a phenomenon educators should be aware of.

“The entire program has objectives and so does a specific learning experience. Objectives of a learning experience may be derived from several sources. All of them result from some type of evaluative process, asking questions about what is needed, what is available, and what are the voids in knowledge. These questions can and should be asked by a variety of people. Through this process several sets of objectives can be developed. The educational institution determines objectives that can be developed. The educational institution determines objectives that the student must achieve (requirements) and that the student may choose to achieve (electives). Clinical centers determine what experiences they have to offer and the objectives for those experiences. The clinical center may also develop objectives and experiences at the request of the academic institution or the students.

“Both students and academic faculty may have unmet needs that they ask the clinical center to meet. The clinical center then assesses its ability to meet such objectives. Student objectives may be determined by a special area of interest, knowledge of the setting in which he or she will be working, or self assessment of personal strengths and weaknesses. All sources can provide important meaningful objectives for learning experiences.

“The clinical center’s function is to make each student clinical experience a coherent experience, and the academic coordinator of clinical education’s function to ensure that all clinical education experiences come together to accomplish those overall objectives deemed appropriate by the academic institution.

“...the three major factors that determine the objectives in physical therapy programs are the health needs of society, the nature of the subject matter, and the characteristics of the learners. A fourth factor, added by some authors, is the profession. The health needs of society are obviously crucial to the development of learning objectives in physical therapy. Health care is changing, both in where it is given and in what is given. The objectives of physical therapy education should reflect that change. The nature of the subject matter is also changing, expanding in both breadth and depth, and the objectives of the curriculum must reflect this. In a field that is changing rapidly, principles or processes rather than specific factual material should be stressed, thus equipping the graduate with tools to cope with new settings and knowledge. The characteristics of the learner are also an obvious consideration in the determination of objectives. Are they graduate students or undergraduates? Are they highly capable and motivated, or taking work because they must?”

### 2. Components of Behavioral Objectives

| a. Audience (the “who”) | Definition: always the learner or patient; never the instructor  
Example: the physical therapy student will... |
|-------------------------|--------------------------------------------------------------------------------------------------|
| b. Behavior (the “what”) | Definition: what the learner must do, demonstrate, or perform  
(use action verbs)  
Example: Describe the physics of an ultrasound machine. Locate the ischial tuberosity. |
| c. Condition (the “when”) | Definition: the circumstances under which the objective will be achieved and/or the tools and equipment necessary to achieve it.  
Example: Following a lecture ...  
Given a skeleton ... |
| d. Degree (the “how well”) | Definition: the level of acceptable performance; how well the learner must perform  
Example: accurately  
within 1 minute |

### 3. Requirements of Well-Written Objectives

a. Student-centered  
   Incorrect: The student will be shown how to perform a sliding board transfer.  
   Correct: Following a demonstration, the student will safely perform a sliding board transfer for a patient with left hemiparesis. (psychomotor)

b. Outcome oriented vs process oriented  
   Incorrect: Within 3 days, the student will research iontophoresis.  
   Correct: Within 3 days, the student will collect 5 articles on iontophoresis.

c. Outcome oriented vs just stating the material to be covered  
   Incorrect: Biomechanical shoulder problems.  
   Correct: The student will explain the biomechanics of the shoulder.

d. Describe 1 outcome only  
   Incorrect: The student will actively seek feedback and remain nondefensive to constructive remarks.  
   Correct: The student will actively seek feedback on his performance.

e. Specific vs general  
   Incorrect: The student will demonstrate initiative.  
   Correct: The student will actively seek out opportunities to observe other physical therapists or physical therapist assistants providing patient interventions.

f. Observable and measurable  
   Incorrect: The student will know the principles of motor learning.  
   Correct: Prior to this week’s inservice, the student will explain the principles of motor learning.
Activity 4
Assessing Behavioral Objectives

1. Are there any components (audience, behavior, condition, degree) missing from the following objectives? If yes, which one(s)?

2. Does each statement satisfy all of the necessary requirements of a well-written objective? If no, why?

3. Rewrite each objective so that it is correct.
   a. Following a lecture, the student will know the steps in applying a below-knee prosthesis.
   b. Following a discussion with the clinical instructor, the student will study the preferred format for documenting initial examinations.
   c. Given all the necessary supplies, the student will correctly demonstrate and explain the proper taping for a “goalkeeper’s thumb” injury.
   d. The student will be shown how to take blood pressure.

(See answer key in Section VII.)
**PREVIOUS ACTIVITY 3A**
**USING DOMAINS TO FOCUS OBJECTIVES**

**Scenario 1:**
Lucy has wonderful examination and evaluation skills. Her examinations are complete, thorough, appropriate, effective, and efficient. However, at midterm, Lucy is still having difficulty planning effective treatment programs. She wants to manage all patients with low back pain the same, all patients with adhesive capsulitis the same, etc. Each time you provide her with a suggestion, she readily incorporates it into her "standard" treatment for that particular diagnosis.

1. List 3 short-term behavioral objectives that Lucy may have to work on to eventually achieve the long-term objective.

*(See answer key in Section VII.)*

---

**PREVIOUS ACTIVITY 3B**
**USING DOMAINS TO FOCUS OBJECTIVES**

**Scenario 2:**
Curt is a PT student on his final clinical experience in an inpatient pediatric rehabilitation unit. He is meeting your expectations within the patient/client management model in the areas of examination, evaluation, and interventions. He is very eager to expand his knowledge base and frequently collaborates with other PT staff members for ideas. Your concern at this point is his limited participation in team meetings. He frequently interrupts other team members and does not seem to listen to their opinions. On occasion, he has also missed meetings entirely. When asked why, he responds that he needed time to plan for a patient and could “catch up” with other team members at any time during the day if he wanted their input.

1. List 3 short-term behavioral objectives that Curt may have to work on to eventually achieve the long-term objective.

*(See answer key in Section VII.)*
F. Characteristics of the Adult Learner

1. Is self-directed

2. Brings experience to learning

3. Is problem-centered

4. Demonstrates readiness to learn

5. Seeks relevant concepts

6. Recognizes there is more than one answer
Activity 5
The Case of Fran (Former Philosophy Major) on Her Final Clinical Experience

Fran mailed her goals for the clinical experience to her center coordinator of clinical education (CCCE) before her clinical experience at an acute care hospital began. On her first day, she told her CI that she was interested in improving her examination skills and gaining the ability to manage her time in an acute care setting.

Her CI has been impressed by Fran’s ability to fit in with the staff and the patients. She attributes her interpersonal skills to her experience as a teacher in a day care center. Fran has asked to be able to select the patients that she manages from each day’s referrals. She maintains a realistic schedule with a caseload of patients with musculoskeletal diagnoses. On several occasions, Fran’s CI has suggested that she manage one of the patients with chronic obstructive pulmonary disease (COPD). Fran said that she is not interested in managing any patients with pulmonary problems because she plans to specialize in pediatrics as soon as she graduates.

1. Which of the characteristics of adult learners do you recognize in this case?

2. Is this a problematic situation? If so, why?

3. How would you reconcile Fran’s interests and the needs of an entry-level clinician?

(See answer key in Section VII.)
ACTIVITY 6
LEARNING STYLES\textsuperscript{6,10}

Complete this checklist about how you learn best.

1. When you study new or complex material, (eg, the muscle spindle), do you prefer:
   - a quiet place, such as a library
   - a comfortable living room, with music playing

2. The best time for you to learn new material is:
   - in the morning
   - in the afternoon
   - late in the evening

3. You have enrolled in a “Spanish for Health Professionals” class that meets weekly. Which method do you prefer to review the material?
   - studying with a small group of your classmates
   - studying independently

4. Your department recognizes your knowledge of neurophysiology and has asked you to present an in-service about the muscle spindle. Your supervisor has allowed you to spend 4 hours of your workday preparing your talk. How would you schedule that time?
   - allow 4 free hours either before or after treating patients
   - schedule alternate hours of patient treatments and in-service preparation

5. Which method would you choose to teach the structure of the muscle spindle?
   - lecture about the spindle
   - ask the audience to build a model of the spindle while you describe the basic structure

6. Which are you most likely to remember?
   - written directions drawn on a map
   - directions that someone has told you

7. You are scheduled to change from the inpatient rotation to the outpatient department. Which supervisor’s approach would be more helpful to you in preparing to treat outpatients?
   - We will meet for an hour each week while you are on the inpatient rotation. During this time, I will review the modalities and manual techniques and give you the articles that you will read. I will assess your performance of the interventions/treatment and quiz you on the content of the articles.
   - Try to spend some time in the outpatient area before you start working here. You should look at the equipment, observe some treatments, and look at our library.

8. The vendor came to demonstrate the use of the new isokinetic equipment while you were on vacation. Which method would you choose to learn to use it for quadriceps femoris muscle strengthening?
   - read the manual
   - it looks similar to other equipment; try to figure it out while strengthening your own knee

9. Soft tissue techniques might lessen your patient’s lumbar pain. To determine whether this intervention would be effective, you would:
   - try the techniques and continue to use them if the patient improves
   - review the theoretical basis for soft tissue techniques to determine whether this intervention is appropriate for this patient.
Activity 6 (continued)

10. What have your responses on the previous page told you about your learning preferences in these areas? Circle the term that correlates with your response.

a. Environmental
   - quiet
   - noise

b. Time of day
   - early
   - late

c. Sociological
   - alone
   - in groups

d. Psychological
   - short bursts of learning
   - long stretches of time spent learning

e. Psychological
   - analytical
   - trial-and-error; reasoner

f. Visual/auditory/kinesthetic/tactile preference
   - tactile/kinesthetic
   - auditory

g. Visual/auditory/kinesthetic/tactile preference
   - visual
   - auditory

h. Organization
   - structured experiences
   - create own structure

i. Learning style
   - concrete experience
   - observation

j. Learning style
   - experimentation
   - conceptualization

11. In what ways are your learning preferences reflected in your teaching style?

12. Do you think a CI’s learning style should be the same as the student’s?

13. In what ways can you match your teaching style to your student’s learning style?
G. Learning Style

1. Characteristic manner of learning or problem solving
2. May vary for different situations
3. Individuals vary in their strengths and weaknesses in acquiring new information or material
4. Learning style affects how you prefer to receive information
   a. visual
   b. auditory
   c. kinesthetic
   d. tactile
5. Learning style affects your preferred method of problem solving
   a. experimenting
   b. conceptualizing
   c. experiencing
   d. reflective observation
5. Learning style is more pronounced when learning new material
6. Teaching style parallels learning style
   a. CI’s and student’s learning styles need not be identical.
   b. Effective teachers consider a student’s learning style when developing learning experiences.
   c. CIs must encourage students to learn to use a variety of learning styles.
   d. CIs can facilitate the development of other learning styles through questioning and in the design of other learning experiences.
5. Learning styles can change over time

H. Learning Style Resources

Additional Information About Learning Styles

1. Kolb Learning Style Inventory
   • Experience Based Learning Systems Inc (EBLS). http://learningfromexperience.com/about/.

2. Myers Briggs

3. Emotional Intelligence
   • Bradberry T, Greaves J. Emotional Intelligence 2.0. San Francisco: Publishers Group West; 2009.

4. True Colors
Activity 7
The Case of Raj
(Labeled a Lazy Learner by Lorraine, His CI)

It is Thursday of the first week of Raj’s second clinical experience. We are listening to his CI, Lorraine, as she speaks with Cheryl, the CCCE.

L: “He never finishes his notes on time. When he is in the staff room, he seems distracted by the conversation and does not write anything down. When we have 5 minutes free between patients, he never bothers to write any notes or use that time to look things up.”

C: “I assume that you have made that one of your objectives for the student for this clinical experience?”

L: “Yes. Objectives are another problem. Ever since I attended the CI workshop, I have found it very effective for the student and CI to set objectives. Every day I have asked Raj to write objectives and he still has not completed them.”

C: “Do you think he is overwhelmed and is forgetting to do things?”

L: “I don’t think so. He has no problem doing anything I tell him, even though he never writes anything down.”

C: “How is Raj doing with designing and writing a plan of care for patients?”

L: “What plan of care? He never seems to plan, but just goes ahead and treats the patients. His motto seems to be treat first, then write a plan that fits with what you have done.”

C: “Are the interventions appropriate and effective?”

L: “Usually. I don’t know how he generates them. You know how the physical therapists from our unit usually get together to discuss patients and brainstorm about possible interventions? Raj never participates in these conversations. I feel like he does not want to be there.”

1. What problems can you identify in this case?

2. What changes would you make in Lorraine’s method of instructing Raj?

(See answer key in Section VII.)
Activity 8
Additional Practice

Examine each of the following behavioral objectives for correctness. a) Does each contain the necessary components? b) Does each meet the requirements (possess the characteristics) of a well-written objective? c) Correct any poorly written objective. d) Identify each component. e) Identify the domain of each objective.

1. The student will distinguish between motor planning problems and weakness in a patient with hemiplegia.

2. By seeking out appropriate guidance from the CI, the student will demonstrate acceptance of limited knowledge and experience.

3. The student will prepare treatment space for an established plan of care for a child with hyperactivity.

4. The student will list appropriate tests and measures for the examination of a patient complaining of knee pain.

5. The student will describe the necessary tests and measures for identification of a torn meniscus and explain the purpose of each test and measure.

6. The student will correctly reproduce a neurodevelopmental treatment program after observing the program two times with the same patient.

7. The student will demonstrate professional behavior.

8. The student will demonstrate the ability to objectively identify manipulative behavior and maintain an appropriate helping relationship.

9. The student will demonstrate the ability to set appropriate priorities by completing assigned responsibilities on time.

10. The student will defend his/her choice of neurodevelopment treatment or proprioceptive neuromuscular facilitation technique in the management of a patient with traumatic brain injury.

11. The student will research the effects of hydrotherapy.

12. The student will be motivated.

13. The student will design a plan of care for a child with cerebral palsy using an integrated program of therapeutic exercise.

14. The student will assess his/her performance following delivery of physical therapy interventions and critically analyze that performance for completeness, effectiveness, and efficiency.

15. The student will document the results of an initial examination thoroughly, concisely, and within 1 hour.

(See answer key in Section VII.)
TAXONOMY OF EDUCATIONAL OBJECTIVES FOR LEARNING

The Cognitive Domain (Bloom, from Ford)

Knowledge
- cite
- count
- define
- draw
- list
- name
- record
- relate
- repeat
- underline

Comprehension
- compute
- describe
- discuss
- explain
- express
- identify
- locate
- report
- restate
- review
- tell
- translate

Application
- apply
- analyze
- appraise
- calculate
- demonstrate
- categorize
- compose
- dramatize
- compare
- construct
- employ
- design
- examine
- evaluate
- illustrate
- formulate
- interpret
- judge
- integrate
- manage
- operate
- organize
- plan
- practice
- schedule
- select
- sketch
- solve
- test
- use

Analysis
- appraise
- assess
- choose
- compare
- criticize
- estimate
- evaluate
- judge
- measure
- rank
- rate
- revise
- score
- select

Synthesis
- arrange
- assemble
- collect
- compare
- criticize
- estimate
- evaluate
- judge
- measure
- rank
- rate
- revise
- score
- select

Evaluation

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## Cognitive Domain: Classification of Behavioral Objectives

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>Remembering by recognition or recall facts, ideas, material, or phenomena</td>
</tr>
<tr>
<td>Comprehension</td>
<td>Understanding the literal message contained in a communication by translation, interpretation, or extrapolation</td>
</tr>
<tr>
<td>Application</td>
<td>Selecting and using technical principles, ideas, or theories in a problem-solving situation</td>
</tr>
<tr>
<td>Analysis</td>
<td>Breaking down material into constituent parts and relating how the parts are organized</td>
</tr>
<tr>
<td>Synthesis</td>
<td>Putting together elements and parts to form a whole that constitutes a new structure or pattern</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Making qualitative and quantitative judgments in terms of meeting criteria</td>
</tr>
</tbody>
</table>
TAXONOMY OF EDUCATIONAL OBJECTIVES FOR LEARNING

The Psychomotor Domain (Simpson, from Ford)

Perception
- distinguish
- hear
- see
- smell
- taste
- touch

Set
- adjust
- approach
- locate
- place
- position
- prepare

Guided Response
- copy
- determine
- discover
- duplicate
- imitate
- inject
- repeat

Mechanism
- adjust
- build
- illustrate
- indicate
- manipulate
- mix
- set up

Complex Overt Response
- calibrate
- coordinate
- demonstrate
- maintain
- operate

Adaptation
- adapt
- build
- change
- develop
- supply

Origination
- construct
- create
- design
- produce

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**Psychomotor Domain: Classification of Behavioral Objectives**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception</td>
<td>Being aware of objects, qualities, or relations through the senses: selecting relevant cues, and relating the cues to motor acts</td>
</tr>
<tr>
<td>Set</td>
<td>Being ready for response to through mental, physical, and/or emotional set</td>
</tr>
<tr>
<td>Guided Response</td>
<td>Imitating the performance of another person and/or repeating performance until correct (trial and error)</td>
</tr>
<tr>
<td>Mechanism</td>
<td>Responding to the demands of a situation with confidence and a degree of proficiency</td>
</tr>
<tr>
<td>Complex Overt</td>
<td>Performing without hesitating and with coordinated muscle control</td>
</tr>
<tr>
<td>Adaptation</td>
<td>Altering basic motor responses to enact demands of new situations</td>
</tr>
<tr>
<td>Origination</td>
<td>Creating new motor acts or ways of manipulating materials</td>
</tr>
</tbody>
</table>
TAXONOMY OF EDUCATIONAL OBJECTIVES FOR LEARNING

The Affective Domain (Krathwohl, from Ford)

<table>
<thead>
<tr>
<th>Receiving</th>
<th>Responding</th>
<th>Valuing</th>
<th>Organization</th>
<th>Characterization</th>
</tr>
</thead>
<tbody>
<tr>
<td>accept</td>
<td>behave</td>
<td>accept</td>
<td>codify</td>
<td>internalize</td>
</tr>
<tr>
<td>attend</td>
<td>complete</td>
<td>balance</td>
<td>discriminate</td>
<td>verify</td>
</tr>
<tr>
<td>develop</td>
<td>comply</td>
<td>believe</td>
<td>display</td>
<td>(formal instruction does not address)</td>
</tr>
<tr>
<td>realize</td>
<td>cooperate</td>
<td>defend</td>
<td>favor</td>
<td></td>
</tr>
<tr>
<td>receive</td>
<td>discuss</td>
<td>devote</td>
<td>judge</td>
<td></td>
</tr>
<tr>
<td>recognize</td>
<td>examine</td>
<td>influence</td>
<td>order</td>
<td></td>
</tr>
<tr>
<td>reply</td>
<td>obey</td>
<td>prefer</td>
<td>organize</td>
<td></td>
</tr>
<tr>
<td></td>
<td>observe</td>
<td>pursue</td>
<td>relate</td>
<td></td>
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<tr>
<td></td>
<td>respond</td>
<td>seek</td>
<td>systematize</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>value</td>
<td>weigh</td>
<td></td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving</td>
<td>Being aware of phenomena and stimuli and willing to control and direct attention</td>
</tr>
<tr>
<td>Responding</td>
<td>Complying with a suggestion, being willing to respond, and responding with satisfaction</td>
</tr>
<tr>
<td>Value</td>
<td>Accepting a value as a belief, preferring the value, and pursuing the value.</td>
</tr>
<tr>
<td>Organizing</td>
<td>Conceptualizing a value and organizing a value system into an ordered relationship</td>
</tr>
<tr>
<td>Characterizing an Internally Consistent Value System</td>
<td>Acting with consistency in accordance with values that are integrated into a total philosophy or world view</td>
</tr>
</tbody>
</table>
REFERENCES


SECTION III

Facilitating Learning in the Clinical Environment
SECTION III: FACILITATING LEARNING IN THE CLINICAL ENVIRONMENT

Introduction
Section III takes the elements of learning, level of domains, stages, qualities of the adult learner, and learning styles and applies them to the process to facilitate learning in the clinical learning environment. Emphasis is on using a learning assessment to create an effective learning environment, designing appropriate learning experiences, and developing supervisory skills. The corollary to the student's readiness to learn is the instructor's readiness to teach. The prerequisite skills include communication, interpersonal relationships, supervision, teaching, evaluation, and competency in clinical skills. Your presence at this course signifies a level of readiness and focuses on another important aspect: the CI's preparation for teaching in the clinical environment.

Objectives
Following the completion of Section III, the participant will be able to:

1. Recognize the resources available to facilitate clinical education.
2. Identify supervisory techniques conducive to effective learning.
3. Apply supervisory techniques for questioning students in a manner that facilitates problem solving.
4. Describe how clinical instruction can be designed to support the development of an adult learner.
5. Recognize the value of feedback in promoting change in student behavior.
6. Recognize the importance of practice in designing appropriate learning experiences.
7. Apply teaching and learning methods to achieve learning goals in the clinical setting.
8. Develop a quality learning experience for a given situation using a systematic process.

Assumptions

1. Effective learning is planned.
2. Effective learning only takes place in a setting that is conducive to learning.
3. The process of clinical education should foster characteristics of adult learning.
4. Feedback is a key ingredient for effective learning.
5. Learning is most effective when the student is an active participant in planning and progressing learning experiences.
6. Practice is essential to effective learning.
7. Effective learning experiences can be many and varied.
A. Process for Designing Learning Experiences

1. Define a “learning diagnosis”
   a. Determine the student’s stage of learning
   b. Determine the student’s level of learning within domains
   c. Determine the student’s learning style(s)
   d. Determine the student’s adult learning qualities
      i. Display all the characteristics of an adult learner
      ii. Take appropriate risks in providing patient/client care
      iii. Demonstrates the ability to analyze the learning situation correctly

2. Consider the available resources
   There are 2 general categories of resources for consideration:
   a. Departmental/facility resources. These resources allow you to provide a breadth of experience for your students to broaden their exposure.
   b. Clinical education resources. These resources allow you to focus the clinical education experience to provide some depth to the experience. They can also be thought of as your clinical education support system.

APTA Guidelines for Clinical Education Sites

“The intent of these guidelines is to provide academic and clinical educators direction and guidance in the development and enhancement of clinical education sites and physical therapist and physical therapist assistant CIs and CCCEs. These documents reflect the nature of current policies and also reflect the future of physical therapy clinical education …”
ACTIVITY 1
RECOGNIZING THE RESOURCES AT YOUR FACILITY

• Consider the resources at your facility.
• Use a “+” to indicate those that you feel are strongly represented in your facility.
• Place a “-” next to those that are present but that could benefit from further development.
• Leave blank those that are not present or that do not occur in your facility.

This activity may be used to stimulate departmental discussion and help you to identify plans for change within your department.

A. Departmental/Facility Resources

Resources in this category assist you in developing the breadth of your clinical education program.

- [ ] Patient variety/types
- [ ] Physical environment (consider available space, equipment)
- [ ] Expertise of clinical staff
- [ ] Interdisciplinary/team approach
- [ ] Community involvement
- [ ] Opportunity to interact with physicians/other disciplines
- [ ] In-service programs (departmental, facility-wide)
- [ ] Opportunity to observe other services (e.g., surgery, cardiac lab)
- [ ] Grand rounds
- [ ] Opportunity for students to practice patient care
- [ ] Opportunity to interact with other students in physical therapy; in other disciplines
- [ ] Opportunity to experience relationships between rehab services and other support departments (i.e., risk management)

B. Clinical Education Resources

These resources allow you to focus the clinical education experience for an individual student. They allow you to provide depth to the experience and to modify the student experience as necessary.

- [ ] Atmosphere receptive to students
- [ ] Staff interested/invested in the clinical education process
- [ ] Staff willing to share expertise
- [ ] Experienced/skilled educator as CCCE
- [ ] Administrative support/commitment to clinical education
- [ ] Written program of expectations for student performance
- [ ] Clinical education policy/procedure manual
- [ ] Support for CI training
- [ ] Staff trained in clinical supervision
- [ ] Mechanism to effectively and efficiently manage communication between the clinical site, academic program, and student should a problem arise Ongoing relationship between staff and the ACCE of the student’s academic program (i.e., opportunities for interaction, sharing of information)

C. Consider ways in which you could strengthen any items identified as “-” or blank.
3. **Develop mutually agreeable behavioral objectives**
   Refer back to Section 2 for developing behavioral objectives.

4. **Plan for weekly learning opportunities**
   a. Document student progress, weekly behavioral objectives and learning activities.
   b. Use the Weekly Planning Form, which allows the clinical instructor to:
      1. Provide regular written feedback
      2. Encourage student self-assessment
      3. Track student progress
      4. Modify weekly goals with student input
      5. Provide feedback in a supportive environment
      6. Promote collegial planning of learning activities
      7. Provide an opportunity to review the past week and assess how closely the student is approaching achievement of the objectives
      8. Revise plans for subsequent weeks to meet student needs
      9. Assess the accuracy of the initial learning diagnosis
     10. Assess the effectiveness of the facility resources
     11. Assess student progress toward achievement of behavioral objectives
**Sample Weekly Planning Form**

Dates: ___________________________  Week Number: ___________________________

**Student’s Review of the Week**
When completing this form consider the five (5) performance dimensions: quality of care, supervision/guidance required, consistency of performance, complexity of tasks/environment, and efficiency of performance.

**CI’s Review of the Week**
When completing this form consider the five (5) performance dimensions: quality of care, supervision/guidance required, consistency of performance, complexity of tasks/environment, and efficiency of performance.

**Goals for the Upcoming Week of ___________________________**

Student’s Signature ___________________________  CI Signature ___________________________
Activity 2
Matching Student’s Level of Preparation to the Objectives

This activity is to practice designing a learning experience by determining a learning diagnosis, considering the facility resources, and developing mutually agreed upon behavioral objectives. Each group will work as a clinical instructor and student who are working together in a supportive environment.

For each of the situations described below, consider the learning diagnosis, then write a behavioral objective for the task described. Then list the background information and facility resources that would be required for the student to successfully complete the objective you have written.

1. Donna is a mature and persuasive third-year PT student on her second full-time clinical education experience. She excelled in her first full-time experience in an outpatient orthopedic practice setting. Consuela, her CI, is an experienced clinical instructor at a 75-bed community hospital. Donna believes that additional medical diagnostics, possibly an MRI, are indicated to better assess the patient. Donna consults with Consuela about obtaining an MRI for the patient. Consuela agrees.
   a. List the background information that needs to be confirmed.
   b. List the applicable facility resources needed.
   c. Write a behavioral objective/goal that you might include on her weekly planning form.

2. Juan is an organized PTA student on his second clinical education experience. Ivan, a novice clinical instructor, is his CI at a large teaching hospital. The physical therapy department regularly teaches a class on safe patient handling techniques to the nursing assistants at the hospital, and the PT director asked Juan to teach the next upcoming class.
   a. List the background information that needs to be confirmed.
   b. List the applicable facility resources needed.
   c. Write a behavioral objective/goal that you might include on her weekly planning form.

3. Suzanne is a PT student, on her second clinical education experience. Marc is her CI in a skilled nursing facility. Marc is also the CI for Dianna, a PTA student on her final clinical education experience. Suzanne has been working on supervising support personnel. Marc asks Suzanne to direct and supervise Dianna in the intervention of a patient, who Suzanne just examined and evaluated.
   a. List the background information that needs to be confirmed.
   b. List the applicable facility resources needed.
   c. Write a behavioral objective/goal that you might include on her weekly planning form.
## Activity 3
### Adult Learning

For each of the items on the left, select all of the guidelines on the right that you feel would assist in promoting that specific characteristic, and provide an example. (You may use each guideline more than once.)

<table>
<thead>
<tr>
<th>Characteristics of the Adult Learner</th>
<th>Guidelines for Promoting Adult Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is self-directed</td>
<td>1. Links new concepts to what students already know</td>
</tr>
<tr>
<td>2. Brings experience to learning</td>
<td>2. Varies teaching methods</td>
</tr>
<tr>
<td>3. Is problem-centered</td>
<td>3. Encourages active learning</td>
</tr>
<tr>
<td>4. Demonstrates readiness to learn</td>
<td>4. Highlights alternative viewpoints</td>
</tr>
<tr>
<td>5. Seeks relevant concepts</td>
<td>5. Models and encourages reflection, not only on performance, but also on interactions with others.</td>
</tr>
<tr>
<td>6. Recognizes there is more than 1 answer</td>
<td>6. Questions assumptions</td>
</tr>
<tr>
<td></td>
<td>7. Acknowledges tension when foreign/new concepts are introduced</td>
</tr>
<tr>
<td></td>
<td>8. Models and discusses decision-making</td>
</tr>
<tr>
<td></td>
<td>9. Is open to other answers as students move forward</td>
</tr>
</tbody>
</table>
6. **Create learning opportunities**
   a. Provide multiple opportunities for practice
   b. Meet more than 1 behavioral objective for the student
   c. Integrate a variety of learning experiences
   d. Minimize negative learning
   e. Consider a variety of teaching/learning methods

7. **Use a variety of teaching methods to structure effective learning experiences**
   The teaching method varies based on the student’s learning diagnosis and the purpose of the learning activity.
   a. Demonstration and practice
   b. Research
   c. “Paper” patients
   d. Patient simulation (role play)
   e. Media resources
   f. Journals (reflective)
   g. Observation
   h. Collaborative learning
   i. Mental Imagery

8. **Maintain a supportive environment**

9. **Use teaching/supervisory techniques**
   Teaching and supervisory techniques set the learning environment, encourage development of adult learning skills, and challenge student learning. Questioning, feedback, and active listening included in this section are emphasized in this course.
   a. Coaching
   b. Time management
   c. Pacing
   d. Role delineation
   e. Practice
      i. When a concept or generalization is to be learned, a specific example should be offered, and the practice activities should be directed toward the achievement of a related skill.
      ii. Students should be allowed to practice new material as soon as possible after it has been presented.
      iii. Practice sessions should be scheduled with intervals sufficient to allow the student to absorb the new material or skill, but not so great as to affect the student’s ability to retain the material.
      iv. The number of tasks and level of difficulty of the task(s) required in a given practice session should be challenging to the student, but not so great as to become overwhelming.
      v. The sequencing of practice should build from simple to more complex activities.
f. Questioning

i. Grouped by function
      • to gain information
      • to sort out facts
   b. Application questions: “How?”
      • apply knowledge in clinical setting
   c. Analysis and evaluation questions: “Why?”
      • how parts relate to the whole
      • how parts relate to each other

ii. Grouped by level of complexity
   • Number of possible correct answers
   • Hierarchy of domains

iii. Type of Questions

<table>
<thead>
<tr>
<th>Category of Question</th>
<th>Information to be Assessed</th>
<th>Sample Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>broadening</td>
<td>knowledge</td>
<td>What are other causes of joint pain?</td>
</tr>
<tr>
<td>reasoning</td>
<td>clinical decisions</td>
<td>How did you arrive at this diagnosis?</td>
</tr>
<tr>
<td>justifying</td>
<td>rationale, evidence</td>
<td>What about this patient suggests joint pain vs other problems?</td>
</tr>
<tr>
<td>hypothetical</td>
<td>synthesis</td>
<td>If this patient were known to be HIV-positive, how might interventions change?</td>
</tr>
<tr>
<td>alternative</td>
<td>integration, evaluation</td>
<td>How might interventions change using current findings versus waiting for an x-ray?</td>
</tr>
</tbody>
</table>


h. Active Listening

i. The skill of becoming involved with what the other person is saying

ii. Ability to attend so closely to what the other person is saying that his/her response generates your next question

iii. Ability to wait patiently for a thoughtful response

iv. Ability to attend to the emotional status of the speaker

v. Ability to create an atmosphere in which the other person feels his/her contributions are valuable
### Activity 4
**Guidelines for Providing Feedback**

#### Information
This activity is to help participants evaluate 2 feedback sessions between a CI and a student. One session portrays ineffective feedback and the other portrays effective feedback. You will observe both feedback sessions in preparation for completing the activity below.

#### Guidelines for Providing Feedback
After observing the “Providing Feedback” practice session, provide an example of each feedback guideline in column 3 based on the observed situation.

<table>
<thead>
<tr>
<th>Feedback is most helpful when it is ...</th>
<th>Feedback is least helpful when it is ...</th>
<th>Practice Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>specific</td>
<td>global</td>
<td></td>
</tr>
<tr>
<td>positive</td>
<td>negative</td>
<td></td>
</tr>
<tr>
<td>useful</td>
<td>directed toward situations that cannot be changed</td>
<td></td>
</tr>
<tr>
<td>supportive</td>
<td>judgmental or evaluative</td>
<td></td>
</tr>
<tr>
<td>given in private</td>
<td>given in front of others</td>
<td></td>
</tr>
<tr>
<td>based on firsthand information</td>
<td>based on “hearsay” or conjecture</td>
<td></td>
</tr>
<tr>
<td>fair</td>
<td>based on only one incident, not a general trend</td>
<td></td>
</tr>
<tr>
<td>honest</td>
<td>obscured by attempts to protect feelings</td>
<td></td>
</tr>
<tr>
<td>constructive</td>
<td>given without suggestions for improvement</td>
<td></td>
</tr>
<tr>
<td>current or timely</td>
<td>delayed by several days or weeks</td>
<td></td>
</tr>
<tr>
<td>focused on behavior, not personality traits</td>
<td>likely to be perceived as a personal attack</td>
<td></td>
</tr>
<tr>
<td>checked for clarity</td>
<td>vague; improperly understood</td>
<td></td>
</tr>
</tbody>
</table>

#### 10. Plan for practice, feedback, and assessment of performance
- a. Consider the type of feedback to be given.
- b. Consider the amount and timing of feedback.
- c. Consider how practice can be provided effectively.
- d. Review guidelines for maintaining open discussions, constructive dialogue, and managing defensiveness.
- e. Document the plan, using the weekly planning form and/or the Student Program Planning Flow Chart.
Student Program Planning Flow Chart

Collaborative planning tool that identifies targeted behaviors from the learning diagnosis, states essential goals, creates related objectives and correlates designed learning experiences using available facility resources. Goals and objectives change as the student progresses through the clinical rotation.

- Allows for a personalized planned learning experiences
- Creates an environment that is conducive to learning
- Allows for student participation in planning and progressing learning experiences
- Targets appropriate objects needed to accomplish the goal
- Promotes learning experiences that are varied and relate to appropriate objectives
- Allows change as the student progresses through the clinical rotation
- Clarifies and encourages the student to complete goals identified for that rotation

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Targeted Behaviors</td>
<td>Long-term Goals</td>
</tr>
<tr>
<td></td>
<td>Objectives</td>
</tr>
<tr>
<td></td>
<td>Learning Experiences</td>
</tr>
<tr>
<td></td>
<td>Available Resources</td>
</tr>
</tbody>
</table>
Activity 5
The Case of Roger
(Completing His Rehabilitation Rotation)

Roger is a physical therapy student on his final clinical internship who is 3 weeks into a 12-week acute rehabilitation clinical experience. You have been noticing that he continues to have difficulty in working with patients with a CVA who have atypical movement patterns. This occurs with patients he is currently treating as well as with new referrals. He is able to correctly explain the physiological and physical aspect of the patterns. He has come to you, obviously concerned about the situation.

a. Identify Roger’s learning diagnosis with an emphasis on the domain of learning and his stage of learning.
b. Using the form provided on the previous page, complete a “Program Planning Flow Chart” for Roger.

Your answers to the questions below will help you complete the sections of the Program Planning Flow Chart.

1. Which behavior needs to improve?

2. What long-term goal can be attained by the midterm?

3. What behavioral objective can be identified and if competed in 1 week will advance Roger closer to his goal?

4. What learning experiences (including teaching learning methods) would be beneficial for the identified behavior to improve?

5. Which resources can be identified in the clinical environment to accomplish Roger’s goal?

(See answer key in Section VII.)
B. Reassess Student Learning – Closing the Loop

1. Hands-on care delivery or skill in manipulating environment

2. Level of questions asked

3. Ability to respond to questions

4. Ability to self-assess

5. Response to feedback

6. Initiative

7. Risk-taking
REFERENCES


ADDITIONAL RECOMMENDED READINGS


SECTION IV

Performance Assessment—The Clinical Environment
SECTION IV
PERFORMANCE ASSESSMENT—
THE CLINICAL ENVIRONMENT

Introduction
Section IV describes Evaluation Principles and a variety of evaluative methods. Formative and summative evaluations are discussed, including use of anecdotal records, critical incident reports, and weekly Planning Forms summaries. Guidelines for effective evaluation are presented. The importance of accurate, objective documentation of student performance is stressed.

Objectives
Following the completion of this section, the participant will be able to:

1. Describe the evaluation process as it is applied in the clinical setting.
2. Describe 2 types of evaluation: formative and summative.
3. Identify selected tools used in providing evaluative feedback to students.
4. Describe common rater errors in performance evaluation.
5. Describe the use of the ratings for summative evaluation instruments.
6. Describe how the different raters in clinical and academic settings interpret the evaluations.
7. Recognize one’s own evaluative skills.
8. Discuss the importance of the student to be able to self-assess his or her clinical performance.
9. Apply performance evaluation as it relates to the student’s academic growth.

Assumptions

1. Decisions in clinical education are based on evaluation. Objective evaluation of student performance drives decision making.
2. Evaluation is an ongoing process with 2 complementary components: formative and summative.
3. Being an effective evaluator requires skill in 3 competency areas: supervision, evaluation, and communication.
4. The ability to self-assess clinical performance is an important component of the clinical education process.
5. Clinical education is not an evaluative process. Rather, evaluation is a tool used in the clinical education experience.
A. Types of Evaluation

1. Purposes of Evaluation
   a. To determine how students are changing
   b. To identify additional learning needed for mastery
   c. To provide feedback to students regarding performance in cognitive, psychomotor, and affective domains
   d. To evaluate the overall effectiveness of a clinical course
   e. To determine whether a student is competent in a procedure
   f. To evaluate the final achievement of objectives
   g. To gather data for determining grades
   h. To assist students in the development of self-assessment skills

2. Formative Evaluation
   a. Used to provide feedback to students during the clinical experience
   b. Used to further learning or modify behavior
   c. Provided during the learning experience
   d. Internal—critical audience is the student
   e. Predictive of summative results

3. Summative Evaluation
   a. Used to summarize performance outcomes
   b. Used for grading or certification
   c. Provided at the end of the clinical experience
   d. External—critical audience is the academic program in addition to the student
   e. Used to set the standards for formative feedback

4. Timing of Evaluation
   a. Begins at once, as soon as the student starts the clinical experience
   b. Continues throughout the experience
   c. Important to evaluate all aspects of student performance so there are no surprises at midterm and the end of the clinical experience

---

<table>
<thead>
<tr>
<th>TYPES OF EVALUATION</th>
<th>Formative</th>
<th>Summative</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE</td>
<td>Process</td>
<td>Outcome</td>
</tr>
<tr>
<td>USE</td>
<td>Promotes Learning</td>
<td>Grading</td>
</tr>
<tr>
<td>TIMING</td>
<td>During</td>
<td>After</td>
</tr>
<tr>
<td>AUDIENCE</td>
<td>Internal</td>
<td>External</td>
</tr>
<tr>
<td>FUNCTION</td>
<td>Predicts Summative</td>
<td>Sets Standards for Formative</td>
</tr>
</tbody>
</table>
B. Formative Evaluation Guidelines and Tools

1. Guidelines for Formative Evaluation

   Counseling sessions or conferences in which you give students formative evaluation should be:

   a. **Individualized.** Tell each student how he or she is doing rather than spending time discussing how “most” students do, or even comparing this student’s performance with that of a group.

      *Example:*

   b. **Goal related.** Focus the discussion on the student’s progress toward clearly specified performance objectives. Be sure the student understands what those objectives are and how his or her performance is being judged.

      *Example:*

   c. **Diagnostic.** Identify specific strengths and weaknesses rather than simply making global comments about overall performance. Anecdotal comments or examples often help to clarify. When problems arise in mastery of complex skills, work with the student to analyze his or her performance to determine where the difficulty lies.

      *Example:*

   d. **Remedial.** Before the session ends, try to work out with the student a practical plan for future activity that will help to maintain present strengths and remedy weaknesses.

      *Example:*

   e. **Collegial.** Collaborate with the student in reaching conclusions and planning future action. Listen, be flexible, and give the student time to put his or her thoughts into words. Recognize that the student knows things about himself or herself that you do not know. Both your verbal and nonverbal behaviors, and the setting in which you meet with the student, will have an important influence on your success.

      *Example:*
f. **Positive.** Be sure to mention the things that the student is doing right. You may also need to identify errors, but be certain that is not the *only* thing you do.

   *Example:*

   

---


g. **Liberative.** Help the student learn to assess his or her own performance and to want to do so.

   *Example:*

   

---


h. **Selective.** Do not try to cover everything in 1 session.

   *Example:*

   

---


i. **Timely.** Try to arrange your schedule so advising can be done soon after the events that need to be discussed. Plan some conferences early so that there is still time to carry out the remedial plan that you and the student develop. Remember that several short sessions carried out at a time when they seem really relevant and fresh may be more valuable than a long, formal session scheduled at some arbitrary time.

   *Example:*

   

---


j. **Reciprocal.** Use these conferences to get ideas about your own strengths and weaknesses as an instructor. Remember that if a student is having problems, you may need to make changes in what you are doing to help him or her improve.

   *Example:*

   

---
2. Useful Formative Evaluation Tools
   a. Professional Behaviors\(^3,4\)
      1. **Critical Thinking.** The ability to question logically; identify, generate, and evaluate elements of logical argument; recognize and differentiate facts, appropriate or faulty inferences, and assumptions; and distinguish relevant from irrelevant information. The ability to appropriately use, analyze, and critically evaluate scientific evidence to develop a logical argument, and to identify and determine the impact of bias on the decision-making process.
      2. **Communication.** The ability to communicate effectively (ie, verbal, nonverbal, reading, writing, and listening) for varied audiences and purposes.
      3. **Problem Solving.** The ability to recognize and define problems, analyze data, develop and implement solutions, and evaluate outcomes.
      4. **Interpersonal Skills.** The ability to interact effectively with patients, families, colleagues, other health care professionals, and the community in a culturally aware manner.
      5. **Responsibility.** The ability to be accountable for the outcomes of personal and professional actions and to follow through on commitments that encompass the profession within the scope of work, community, and social responsibilities.
      6. **Professionalism.** The ability to exhibit appropriate professional conduct and to represent the profession effectively while promoting the growth and development of the physical therapy profession.
      7. **Use of Constructive Feedback.** The ability to seek out and identify quality sources of feedback, reflect on and integrate the feedback, and provide meaningful feedback to others.
      8. **Effective Use of Time and Resources.** The ability to manage time and resources effectively to obtain the maximum possible benefit.
      9. **Stress Management.** The ability to identify sources of stress and to develop and implement effective coping behaviors; this applies to interactions for self, patients/clients and their families, and members of the health care team, and in work/life scenarios.
      10. **Commitment to Learning.** The ability to self direct learning to include the identification of needs and sources of learning, and to continually seek and apply new knowledge, behaviors, and skills.

   b. Weekly Planning Form (refer to Section 3 for information about the weekly planning form)

   c. Anecdotal Record
      1. Useful as an adjunct to summative evaluation but does not stand alone well
      2. Can be used to document positive or negative behaviors
      3. Useful in supporting ratings/scores, especially for students with poor affective behaviors and for students who excel
      4. Separates interpretation from student action
      5. Requires student signature
ANECDOTAL RECORD

Student: ___________________________ Date: ___________________________

Evaluator/Observer: ___________________________

Setting (place, people involved, atmosphere, etc): ___________________________

Student's Action or Behavior: ___________________________

Evaluator's Interpretation: ___________________________

Student's Signature_________________________ Evaluator's Signature_________________________

Student's Comments: ___________________________

Activity 1
The Anecdotal Record

Directions: Using the information in the narrative below, complete the blank Anecdotal Record on the previous page as if you were planning to share it with your student. First record what happened. You may then add your own interpretation; however, avoid combining your judgment with the facts.

Jane is beginning week 3 of her second clinical experience in a subacute rehabilitation facility in her hometown. Her first experience was in an outpatient orthopedic private practice. Jane readily admits that she needs a lot of assistance at first in maintaining control of the therapist patient interaction, especially with some of the more aggressive patients and those who challenge her every word. This has improved as she has become more familiar with the facility, the caseload, and her clinical instructor.

Mrs J is an 86-year-old woman admitted from the acute care facility after having slipped on an area rug in her home (where she lives alone) and fracturing her hip. Her history of diabetes has complicated her rehabilitation somewhat. Mrs J is viewing her stay in this subacute facility as the opportunity to take a little vacation, catch up on her phone calls to friends, and play a little cribbage with the woman in the next bed.

In this subacute setting, the therapy staff actively involves the patients in deciding their therapy times. They then inform the nursing staff of the therapy schedule for the next day to ensure that patients are up and ready. However, twice within the last week, Mrs J has adamantly refused therapy. Jane is not sure how reliable Mr. J’s complaints/refusals are.

Today, Robert, Jane’s clinical instructor, is interested in observing Jane’s interaction with Mrs J. So as not to disrupt the session, Robert arrives just after Jane, but remains in the hallway, within easy listening distance.

Jane enters Mrs J’s room, to find her on the telephone with one of her neighbors from home. Jane briefly interrupts Mrs J to tell her that it is time for her scheduled appointment. When Mrs J makes no move to end her conversation, Jane again interrupts Mrs J to say that she will return in a minute and expects to see that the conversation has ended. When Jane returns a few minutes later, she again interrupts Mrs J and firmly, but politely, asks her to hang up because she has agreed to have her treatment at this time. Mrs J looks somewhat surprised, but appropriately hangs up.

(See answer key in Section VII.)
d. Critical Incident Report
   1. Useful *adjunct* to summative evaluation, but not useful alone
   2. Can be used to document a series of similar behaviors, usually problem behaviors
   3. No interpretation by observer; just states facts
   4. Includes *clearly stated consequences* for the behavior
   5. Requires student signature

THE CRITICAL INCIDENT REPORT

*Directions: Record each entry clearly and concisely without reflecting any biases.*

<table>
<thead>
<tr>
<th>Date (Time)</th>
<th>Antecedents</th>
<th>Behaviors</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Student’s Initials:*

*Evaluator’s Initials:*

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
</table>

*Student’s Initials:*

*Evaluator’s Initials:*

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</table>

*Student’s Initials:*

*Evaluator’s Initials:*

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<table>
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<th></th>
</tr>
</thead>
</table>

*Student’s Signature:*

*Evaluator’s Signature:*

Activity 2

The Critical Incident Report

Directions: Given the information in the narrative, complete the Critical Incident Report on the previous page as if you were planning to share it with your student. Disregard the “specific times.” Create your own consequences.

Bruce is completing the fourth week of his second full-time clinical experience on an inpatient rotation at St John’s Hospital. He previously completed an 8-week experience in an outpatient private practice. His previous clinical experience was uneventful except for frequent reminders to adjust the aggressiveness of interventions. He required reminders to consider the entire patient and the patient’s response to interventions, not just the single joint on which he was working.

During the first week of this clinical experience, Bruce’s clinical instructor, Karen, became concerned with Bruce’s lack of attention to detail as it related to total patient care, and lack of respect for the patients and their needs. She mentally noted a number of instances, such as failure to use a gait belt, lack of attention to setting up the environment in the patient’s room prior to providing interventions, lack of attentiveness to the patient’s needs, or asking about level of pain. As incidents were identified and discussed, they did not recur. However, Karen was concerned that new examples of this failure to attend to detail and lack of respect for the patient and his or her needs continued to surface. She wanted to find a way to emphasize the seriousness of these incidents to Bruce, let him know that he was jeopardizing his patients’ welfare by failing to look at the big picture and being sensitive to their needs, and inform him in no uncertain terms that a change in his approach was required. She decided to use the Critical Incident Report format to document the following additional instances.

During the first week of the clinical experience, having observed Karen treat a similar case the day before, Bruce successfully instructed a 76-year-old woman with a total hip replacement, in non-weight bearing with a walker. This was the first time ambulating since her surgery, and Bruce did a nice job with patient instructions and demonstration. Bruce appeared to be in control of the situation, as Karen stopped briefly to fill in one of the nurses about another patient. When she glanced down the hallway a few moments later, she was appalled to see that Bruce had let go of the gait belt and was apparently texting a message on his phone. He did not notice the incorrect gait pattern or the visible signs of distress on the face of his patient.

During the second week of this acute clinical experience, Bruce was transferring a patient from wheelchair to bed, a task he had performed many times in the last couple of weeks. As he assisted the patient to standing, the wheelchair began to move. Rather than sit the patient down to correct the error, Bruce continued with the transfer.

Bruce’s third and fourth weeks have been spent on the cardiopulmonary unit at St John’s. Very strict protocols, policies, and procedures are adhered to on this unit. Karen thoroughly reviewed all pertinent policies and procedures with Bruce, and the importance of each was discussed. However, Karen has frequently noted a troubling lack of detail in the notes Bruce has written and that pertinent information about the patient’s needs was absent. Important information is missing. It is discovered, upon questioning, that Bruce has only sporadically done a thorough chart review and patient interview.

(See answer key in Section VII.)
C. Summative Evaluation Guidelines

1. Guidelines for Summative Evaluation

   General Principles:
   Careful evaluation should be used as a mechanism to determine strengths and weaknesses of the individual student, as well as the effectiveness of the academic and clinical programs. Although any rating method will be somewhat subjective, every precaution should be taken to make it as objective as possible by following these accepted principles of rating.

   a. The rating process:
      i. Students should be rated on the basis of definite observations made of his or her work and behavior. Do not guess. (If you have had insufficient opportunity to observe the objective in question, and consultation with other staff is not helpful, your response should be “No” or “Not observed enough to evaluate.” However, if you have discussed the criterion with the student without actually observing his/her performance, make a note of the discussion in the comments.)
      ii. Students should be rated on the basis of typical and frequent manner of performance rather than on isolated instances. Do not rate based on one observation only. This should be “No” or “Not observed enough to evaluate.”
      iii. Students should be rated on the basis of typical and frequent manner of performance at this point in time. Do not average performance over the first half of the clinical experience. Use the comment section to indicate that change in performance has occurred.
      iv. Become “rating conscious” by familiarizing yourself with the rating form in advance so you know what you are asked to observe. Look for concrete instances in the daily work of the student that will help you formulate your judgments. The more instances you can cite, the better able you will be to support your rating in discussions with the student.
      v. Become knowledgeable about common types of rater error. Awareness of typical errors will increase the objectivity of your assessment.
      vi. Unless instructed to do so, do not average grades within a section or make extraneous markings. Follow the specific directions provided with the evaluation instrument.
      vii. Use the comment section to document and clarify ratings (score, rating, markings) that are below or above the norm or expectations. Use of the comment section is crucial for any evaluation tool but especially for the CPI, to support and be consistent with the mark on the VAS or categorical scale.
      viii. Use the CPI Performance Dimensions to rate performance and guide comments:
         1. Quality of care
         2. Supervision/guidance required
         3. Consistency of performance
         4. Complexity of tasks/environment
         5. Efficiency of performance

   b. Using the report
      i. It is suggested that the student’s performance be evaluated at midpoint. If the student is doing well, give him or her this assurance as well as constructive criticism that may guide him or her to even better performance. If there are areas that need improvement, indicate this and give positive suggestions for improvement.
      ii. At mid- and final evaluations, discuss the completed form with the student, have him or her sign it, and forward it to the school.
2. **Strategies for Conducting an Evaluation Session**

a. Clearly establish the goals you are working toward and the objectives that describe those goals.
b. Be consistent with your expectations of the student and be open about sharing your observations with the student in a timely manner.
c. Use examples and be as specific as possible.
d. Engage the student in both evaluating himself or herself and reacting to your evaluation.
e. Be sure to listen as well as to speak.
f. Practice a combination of assertiveness and cooperation when dealing with a potential or actual problem situation.

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>CRITIQUE</th>
<th>IMPROVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “This is hard to evaluate for the student's level.”</td>
<td>Evaluation scores address observable behavior, not a subjective assessment of progress.</td>
<td>Give the student a rating/score based on the criteria outlined in the evaluation form, regardless of his or her level.</td>
</tr>
<tr>
<td>2. “With more experience, she hopefully will improve in...”</td>
<td>This is conjecture, not fact. We hope that the student will improve with more experience, but we cannot allow this subjective “hope” for future student performance to color our assessment of her performance at this time.</td>
<td>Give the student an objective rating/score, based on the criteria outlined in the evaluation form.</td>
</tr>
<tr>
<td>3. “His performance was OK, but could have been better.”</td>
<td>This is not useful feedback, as it is much too vague. Any student would have difficulty deciding what he was supposed to change.</td>
<td>Be specific about what needs to be modified.</td>
</tr>
<tr>
<td>4. “This problem dates back to his first week of clinical experience.”</td>
<td>If this is the case, the expectation is that it has been addressed in a variety of ways since that time. If there has been no attempt at remediating the “problem,” why not?</td>
<td>You should be able to provide documentation of all attempted remediation techniques and their outcomes, using formative feedback tools.</td>
</tr>
<tr>
<td>5. “She needs a better attitude toward patients, as evidenced by her performance during bedside care.”</td>
<td>Attitudes are difficult to assess. This statement does not make it clear to the student what behavior is a problem.</td>
<td>Be objective and specific by noting observable behaviors. Use anecdotal records to document and describe specific situations.</td>
</tr>
</tbody>
</table>
3. Common Rater Errors in Performance Evaluation

a. **Halo or reverse-halo effect.** Allowing the value of 1 item to positively (or negatively) influence your grade in another item.

b. **Rater mood or memory.** Allowing your mood to affect the grades you assign to a student. Making judgments of student’s performance based on unclear recollections.

c. **Error of central tendency.** The tendency for raters to grade toward the center of the scale, whatever the scale might be. The entire scale should be considered and used if appropriate. Failure to use the whole scale when appropriate does not adequately distinguish between a student’s abilities.

d. **Proximity error.** Allowing 1 item to affect your score on the next item, simply because of each item’s proximity to the other.

e. **Error of leniency.** The tendency to be more lenient in rating student you know well, or going disproportionately out of your way to avoid leniency.

f. **Initial impressions.** Allowing the first impression left by a student to affect your later judgments about performance of a specific skill.

g. **Logical error.** The tendency to rate items similarly simply because some traits are logically quite similar to others, without making the necessary distinctions between traits.

h. **Contrast effect.** In which the quality of the previously rated student will often affect judgment about the student being rated.

i. **Similarity of background.** Allowing your judgment to be affected by the degree of similarity between you and the student being assessed with respect to background, attitudes, and ethnic group. It has been shown that greater similarity tends to produce more favorable decisions. Diversity describes the many differences and similarities that exist between people. Some of these are apparent such as race and gender. Some of these differences are less obvious—cultural background, religious morals and values, education, social status, age, lifestyle, and political views. All of these dimensions may influence evaluation of performance. Covert bias due to race and ethnicity was shown to exist in evaluating student performance in a study by Haskins, et al.⁶
4. Summative Rating Scales and Their Use

    **Rating Scales**

    a. Checklist
        i. Rating absence/presence (yes/no) only
        ii. Often in task analysis format—useful in remediation of challenging student situations
        iii. Least subjective of all tools
        iv. Most difficult to use correctly
        v. Does not allow for nuances in performance ratings

    **EXAMPLE 1**

    **CHECKLIST**

    The following rating scale has been developed for use with the PT MACS:

    | Rating | Description |
    |--------|-------------|
    | +      | Above entry-level. Surpasses entry-level standards for this setting by meeting all applicable objectives; practices the skill safely, effectively, consistently, and efficiently. |
    | ✓      | Entry-level. Meets entry-level standards for this setting by meeting all applicable objectives; practices the skill safely and effectively. |
    | NI     | Not Independent. Below entry-level standards for this setting; does not meet all applicable objectives; practices the skill with supervision or assistance from the CI, requiring guidance and/or correction. Requires comment by CI. |
    | U      | Unacceptable. Well below entry-level standards for this setting; does not meet applicable objectives even with repeated assistance from CI to correct deficits; practices the skill in an unsafe and/or ineffective manner even with repeated guidance from CI. Requires comment by CI citing incidents/reasons for the rating; CI or CCCE must call DCE or ACCE as soon as possible once the student earns this rating. |
    |        | Blank. Student has had no opportunity to practice the skill in this setting. |


A. Basis for the Rating Scale

1. The PT MACS is designed so that the skills can be completed in a variety of practice settings.
2. The student may encounter facilities where certain objectives for the skill are not performed routinely by the physical therapist.
   - If this is the case, then the student should be rated based only on the objectives that are applicable for that facility.
   - The student should not be expected to fulfill an objective if that objective is not applicable at the facility.
   - At the beginning of the internship the CI should identify:
     - Objectives applicable to the setting
     - Expectations of the student in order to earn an entry-level (✓) rating

    *Note: Ratings should be based only on the objectives applicable at the facility in which the student is completing the internship.*
EXAMPLE 1
CHECKLIST 1 (CONTINUED)

B. Explanation of the NI and U Ratings
   1. NI rating: The student is not independent because of 1 or more of the following:
      • Student requires cueing, prompting, reminding, instructing, guiding, or correcting to perform applicable objectives for the skill.
      • Student is not safe in performing the skill.
      • Student demonstrates errors in performance of the skill.

   Note: CI must document specific behaviors that need improvement, referring to the objectives of the skill when applicable.

   2. U rating: The student’s performance is unacceptable because of 1 or more of the following:
      • Student engages in a single grievous incident that demonstrates gross unprofessional, unsafe, illegal, or unethical behavior.
      • Student continues to perform the skill in an unsafe or ineffective manner even after receiving repeated guidance from the CI including written documentation of the incident(s) or problem(s).

   Guidelines for Documenting the U Rating
   • Document the specific behavior(s) that resulted in the U rating citing objective(s) that apply to the rating.
   • Document the extent and type of guidance, instruction, or counseling provided to the student leading up to the U rating.
   • If the documentation exceeds the space available for comments in the PT MACS, the CI must sign and date all additional documentation.
b. Numeric Rating Scale  
i. Rater able to qualify a response; not only can the student do something, but also how well can he or she do it  
ii. Can appear as descriptive- numeric format (Example 1), or graphic format (Examples 2 and 3)  
iii. Easy to use  
iv. Used in conjunction with formative tools  
v. Can be subjective and must follow summative evaluation principles to avoid bias (ie, typical rating errors)  
   • each objective operationally defined (Example 2)  
   • visual analog scale (Example 3)  

**Example 2**  
**Numeric Rating Scale**

**Definitions**  
The following definitions are provided for consistency and clarity. Please use the rating scale below to indicate the student’s level of competence for each of the stated objectives.  

4 **Consistently meets the stated objective. The student seeks confirmation from the clinical instructor.**  
   Confirmation. Student confers with the clinical instructor prior to or following an activity for the purpose of sharing information or validating decision making. The student is capable of functioning safely and independently.  

3 **Consistently meets the stated objective. The student needs guidance from the clinical instructor.**  
   Guidance. Student needs advice from the clinical instructor to expand knowledge or skills. The presence of the clinical instructor in the immediate vicinity is not necessary.  

2 **Meets the stated objective with inconsistencies. The student requires supervision from the clinical instructor.**  
   Supervision. The student needs verbal cueing or physical assistance from the clinical instructor. The presence of the clinical instructor in the immediate vicinity is necessary.  

1 **Does not meet the stated objective. The student requires constant supervision from the clinical instructor.**  
   Constant Supervision. The student requires continuous verbal cueing or continuous physical assistance from the clinical instructor.  

N/A Not Applicable: Objective not applicable to this clinical situation  
N/O Not Observed: Objective not observed to the extent that a rating is appropriate.
The PTA CPI: Version 1998 allowed the rater to assess student performance based on outcome performance criteria. The rater indicates on the visual analog scale (VAS), using a vertical line that intersects the scale, where the student's performance falls on the continuum from novice clinical performance to entry-level performance at both midterm and final evaluations. Sample behaviors accompany each performance criterion to guide the assessment of the student's competence relative to the performance criterion. In addition, the rater has the option of checking the “With Distinction” box indicating that the student's performance on the criterion exceeds expectations for that specific clinical experience. Note that this scale allows the rater to indicate any performance criterion that was not observed. The rater may also check the “Significant Concerns” box if the student's performance on a criterion is problematic such that the student is at risk of failing. This box provides for an early warning signal (to be discussed further in Section V) to the student and the academic program. When this box is checked it warrants a call to the ACCE/DCE to discuss the student's performance problems as early as possible and to develop an action plan to address any performance issues.

**Example 3**

**Visual Analog Scale: APTA Clinical Performance Instrument (PTA CPI)**

1. Performs in a safe manner that minimizes risk to patient, self, and others.

<table>
<thead>
<tr>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
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<tr>
<td>M</td>
<td>F</td>
</tr>
</tbody>
</table>

   **Significant Concerns:** Check below if performance on this criterion places student at risk for failure of this clinical experience.

<table>
<thead>
<tr>
<th>M</th>
<th>F</th>
</tr>
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</table>

   **Key:** M = Midterm; F = Final

The PTA CPI: Version 1998 allowed the rater to assess student performance based on outcome performance criteria. The rater indicates on the visual analog scale (VAS), using a vertical line that intersects the scale, where the student's performance falls on the continuum from novice clinical performance to entry-level performance at both midterm and final evaluations. Sample behaviors accompany each performance criterion to guide the assessment of the student's competence relative to the performance criterion. In addition, the rater has the option of checking the “With Distinction” box indicating that the student's performance on the criterion exceeds expectations for that specific clinical experience. Note that this scale allows the rater to indicate any performance criterion that was not observed. The rater may also check the “Significant Concerns” box if the student's performance on a criterion is problematic such that the student is at risk of failing. This box provides for an early warning signal (to be discussed further in Section V) to the student and the academic program. When this box is checked it warrants a call to the ACCE/DCE to discuss the student's performance problems as early as possible and to develop an action plan to address any performance issues.

c. Categorical Rating Scale (Example 4)
   
   i. Well defined anchors provide for specific conditions that all must be met to mark on an anchor or above the anchor in an interval.
   
   ii. Ratings should triangulate with comments provided when selecting a rating; provides for an internal check of comments with rating.
   
   iii. May be more difficult to use given anchor definitions
   
   iv. Used in conjunction with formative tools
   
   v. Must follow summative evaluation principles to avoid bias (ie, typical rating errors)
   
   vi. In the case of the PT CPI, requires successful completion of an online training component to be completed prior to use.
EXAMPLE 4
CATEGORICAL SCALE: APTA PHYSICAL THERAPIST
CLINICAL PERFORMANCE INSTRUMENT (PT CPI)\textsuperscript{10}

2. Demonstrates professional behavior in all situations.

SAMPLE BEHAVIORS

a. Demonstrates initiative (e.g., arrives well prepared, offers assistance, seeks learning opportunities).
b. Is punctual and dependable.
c. Wears attire consistent with expectations of the practice setting.
d. Demonstrates integrity* in all interactions.
e. Exhibits caring,* compassion,* and empathy* in providing services to patients.
f. Maintains productive working relationships with patients, families, CI, and others.
g. Demonstrates behaviors that contribute to a positive work environment.
h. Accepts feedback without defensiveness.
i. Manages conflict in constructive ways.
j. Maintains patient privacy and modesty.
k. Values the dignity of patients as individuals.
l. Seeks feedback from clinical instructor related to clinical performance.
m. Provides effective feedback to CI related to clinical/teaching mentoring.

*Words denoted with an asterisk are defined in the PT CPI glossary.

Midterm Comments: (Provide comments based on the performance dimensions including supervision/guidance,* quality,* complexity,* consistency,* and efficiency.*) ____________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Final Comments: (Provide comments based on the performance dimensions including supervision/guidance,* quality,* complexity,* consistency,* and efficiency.) ____________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Rate this student’s clinical performance based on the sample behaviors and comments above:

Beginning Performance  Advanced Performance  Intermediate Performance  Advanced Performance  Entry-level Performance  Beyond Performance

Significant Concerns: If performance on this criterion is unacceptable, check the box and call the ACCE/DCE.

\[\text{Midterm} \quad \text{Final}\]
The PT CPI: Version 2006 allows the rater to assess student performance on 18 outcome performance criteria. All 18 performance criteria are to be rated for all experience levels of clinical education. Prior to marking the rating scale, the rater reviews the Sample Behaviors that accompany each performance criterion. Using the sample behaviors and the five Performance Dimensions (page 38), comments are provided to guide the assessment of students’ competence relative to the performance criterion.

The rating scale consists of 6 well-defined anchors designed to reflect a continuum of performance ranging from “Beginning Performance” to “Beyond Entry-Level Performance.” Student performance is described in relation to one or more of these six well-defined anchors. This rating scale is not designed to be a visual analog scale. The vertical mark indicates that the student has exceeded the anchor definition of “intermediate performance”; however, the student has yet to satisfy the definition associated with “advanced intermediate performance.” In order to place the rating on an anchor, all of the conditions of that level of the rating must be satisfied as provided in the description for each of the 6 anchors. The rater may also check the “Significant Concerns” box indicating that the student’s performance on this criterion is unacceptable for this clinical experience. The significant concerns box provides an early warning system to identify student performance problems thereby enabling the CI, student, and ACCE/DCE to determine a mechanism for remediation, if appropriate.

The PT CPI: Version 2006 requires that all users (CIs, CCCEs, ACCEs/DCEs, and students) complete an online training and assessment program and achieve a passing score of 70% or higher. This training program is offered through the APTA Learning Center (http://learningcenter.apta.org/) and consists of 5 modules that include all of the essential information to accurately and consistently use this instrument. The PT CPI: Version 2006 is only available as a Web-based instrument (PT CPI Web) and only to those who have successfully completed the online training and assessment. Physical therapist academic programs purchase an annual subscription through Academic Software Plus to access the PT CPI Web, which allows students, CIs, CCCEs, and ACCEs/DCEs to use the customized software (www.apta.org/ptcpi). Contact the physical therapist program’s ACCE/DCE for specific questions about using the PT CPI Version 2006 or the PTA CPI Version: 2009.

**Perspective of Raters Using the Different Scales**

- **Students**
  - Students seek clear and objective information about their performance.
  - Students look for indications of changes in their performance from mid- to final evaluation periods, and review description narrative for how those changes have been demonstrated based on the sample behaviors and performance dimensions.
  - Should know how they are performing throughout the experience as supported by summative feedback.
  - Formative performance evaluations at mid and final evaluations should not be a surprise to students.

- **CIs**
  - CIs seek clarity in how to use the specific performance assessment tools accurately.
  - CIs prefer assessments that provide opportunity to show degree of change in performance to the student and academic program.
  - CIs seek systematic and objective evaluation tools that can be used consistently with all students.
  - CIs need to feel comfortable that their role is to objectively assess students’ performance and the role of the academic program to provide the grade based on that evaluation and other program requirements.

- **CCCEs**
  - CCCEs review performance assessments provided by CIs as a part of their professional development in conducting evaluations.
  - CCCEs attest that the CI performance assessment of the student was completed and reviewed.

- **Academic Program**
  - It is important to the academic program that CIs and students use performance evaluations consistently.
  - The academic program bases decisions on student performance on CIs’ objective performance evaluations of students.
  - It is important for the academic program to compare student self-assessments with ratings from CIs to evaluate degree of agreement and/or variance between the ratings.
  - Grading of student performance is based on the CI’s rating of the student along with other additional requirements determined by the academic program and the clinical site.
Summary

- Evaluation must include timely, specific feedback.
- Evaluation should promote student self-assessment and learning.
- Formative and summative evaluation tools are used to document behavior.
- Raters should know how to use the evaluation tools. Raters should be able to identify the strengths and limitations of different rating scales. Raters should minimize subjectivity.
- Raters should be cognizant of the different types of rater errors.
- CIs and CCCEs should contact the ACCE/DCE early if there are any questions or student performance issues.

Final Question

What 1 thing will you change in the future as you evaluate student performance?
REFERENCES


Acknowledgments
Some of the information contained in this section is used with permission from the presentation “Legal Context for Evaluating and Dismissing Physical Therapy Students” by Steve Milam, senior counsel and assistant attorney general, Health Sciences and Medical Centers, University of Washington, Seattle, Washington.
SECTION V
LEGAL, REGULATORY, AND ADA ISSUES IN CLINICAL EDUCATION

Introduction
Section V reviews the legal context in which the evaluation and dismissal of physical therapist and physical therapist assistant students are viewed. The discussion includes the view of the courts regarding intervening in academic matters, as well as the legal principles and processes involved when a legal decision is required. References are made to actual case outcomes. Documentation of the student’s performance is discussed. Discussion also addresses the responsibilities of the clinic when a student requires reasonable accommodations consistent with the American with Disabilities Act (ADA). In addition, student supervisory issues are addressed in relation to federal regulations and APTA policy, positions, and guidelines.

This discussion is not to be construed as legal advice or counsel. All participants are directed to consult legal counsel for actual situations that occur related to clinical education.

Objectives
Following the completion of this section, the participant will be able to:

1. Identify the legal requirements for a high-quality educational experience, including a clinical affiliation agreement.
2. Apply documentation formats to maintain a clear academic record.
3. Discuss how courts view litigation of academic issues.
4. Examine issues related to students with disabilities and implications for clinical education.
5. Discuss the legal and supervisory responsibilities of the clinical educator.
6. Locate references and resources associated with legal, regulatory, payer, employer, and profession-based supervisory responsibilities in clinical education.

Assumptions

1. Educators have legal as well as ethical responsibilities to students, to the academic institution, to the clinical facility, and ultimately to patients or clients.
2. Documentation of the clinical education process must be sufficiently clear, accurate, thorough, and timely to demonstrate the quality and consistency of the educational experience.
A. Clinical Affiliation Agreement

The clinical affiliation agreement is a contractual document that is legally binding. The agreement specifies the roles and responsibilities of the involved parties, in this case the academic institution and clinical facility. Although duly authorized individuals are required to sign this document, it is still the responsibility of those parties who will carry out the contract to have read the document and to be in full compliance with the conditions specified therein.

Clinical affiliation agreements are generally reviewed and negotiated by legal counsel or other duly authorized individual(s) within higher education and the clinical facility. The parties that are involved in the contract are also delineated. Although language used in clinical affiliation agreements vary between academic institutions and clinical facilities, required elements include:

1. Specific responsibilities of the academic institution, clinical facility, and student in providing a clinical placement
2. Specification of the conditions and time frame under which the contract may be broken, including the length of time in which the contract is in effect
3. Identifies the method and frequency of evaluations
4. Requirements for the award of student credit and satisfactory course completion
5. The method for resolution of disputes and the authority for and process of termination
6. Required malpractice insurance coverage of the student
7. Statement regarding liability of the parties involved in the contract (eg, hold harmless, double indemnity clause)
8. Specification of any information that must be provided about the student that is not in violation of the Buckley Amendment, such as specific required immunizations or tests, or health records on file
The Case of a Student Dismissal

A student is completing her final 12-week clinical experience at a large inpatient rehabilitation hospital. This student’s performance has successfully met expectations for all classroom and prior clinical education experiences. The student has a slow start and is fearful of this clinical experience because she has not had any prior experience in adult rehabilitation or with patients with complex neurological conditions. She is diligent in preparing for patients that she will be seeing and routinely asks questions about managing complex neurological patients with various conditions.

Clinical Instructor Observations—Week 1

The CI used the Weekly Planning Form for the first week of the clinical experience but did not continue its use in subsequent weeks.

Midterm Performance Evaluation:
- Narrative comments reflect slow progress in all performance criteria.
- Ratings on the categorical scale are in the interval between beginner performance and advanced beginner performance anchors on the CPI.
- The CI has completed no critical incident reports.
- Summative comments by the CI indicate the student’s performance is a little behind expected performance but anticipates that the student will meet expectations in the next 6 weeks.
- There is no indication on the CPI that the student is at risk on any performance criterion (mid-evaluation at-risk box is not checked).
- No call is placed to the ACCE/DCE.

Based on this mid-evaluation, the student feels confident that although she got a slow start, she is progressing satisfactorily to successfully meet the performance expectations at the completion of this experience. The student assumes that she is performing in ways that continue to progress and meet expectations. The CI orally lets the student know that she is still demonstrating problems meeting expected clinical performance.

Final Performance Evaluation:
- Narrative comments indicate that the student is slowly progressing on several performance criteria.
- Ratings on the categorical scale for the performance criteria are at the advanced intermediate level and in the interval between below and well below entry-level performance.
- CI does not mark the “at-risk” box.
- Summative written comments at the end of the CPI do not reflect the seriousness of the student’s problem.
- CI and student review the completed CPI and sign the evaluation instrument.

The student leaves with the impression that she has successfully passed the clinical experience.

The ACCE/DCE receives the completed CPI and a note from the CI stating that this student’s performance has not met performance expectations. Based on the CI’s CPI evaluation of the student, she should not pass the clinical experience. This is the first time that the ACCE/DCE is aware that there has been any problem with this student, and the documentation that is provided does not seem to consistently substantiate the CI’s recommendation. The ACCE/DCE contacts the CI and asks whether the student was informed that her performance was unacceptable. The CI indicates that she had been letting the student know all along that she was progressing more slowly than expected and she was made aware that she needed work. At this point, the ACCE/DCE recognizes that this situation is potentially problematic and litigious.
B. Principles That Define the Legal Context for Evaluation and Dismissal of Students

1. The court will not overturn academic decisions.
   a. Courts recognize 4 essential freedoms of the university:
      i. who may teach
      ii. what may be taught
      iii. how it shall be taught
      iv. who may be admitted to study

2. Faculty are encouraged to uphold high academic standards.
   a. The faculty should use their professional judgment and assess the entire record of the student.
   b. Faculty have duties to candidly and critically evaluate a student. These duties are owed to three groups:
      • the student
      • patients/the public
      • the profession
   c. Faculty decisions will be upheld if they are not arbitrary or capricious.
      i. “Arbitrary and capricious action is willful and unreasoning action without consideration and in disregard of facts or circumstances.”
      ii. “When there is room for two opinions, action is not arbitrary or capricious when exercised honestly and upon due consideration, even though it may be believed that an erroneous conclusion has been reached.”

3. Faculty are encouraged to identify students with problems early and to provide assistance.
   a. Faculty are encouraged to develop an “early warning system” (EWS).
   b. The EWS needs to:
      i. identify problems
      ii. define what it will take to resolve problems
      iii. define performance criteria expectations that leave no questions regarding successful outcome
      iv. define timelines for improvement
   c. Educators need to ensure that the student sees all documentation about his or her performance, including information reported by other staff.
   d. The EWS allows objective assessment of the course of the student’s progress:
      i. the student’s performance improves
      ii. the student denies his or her problems
      iii. the student tries to improve, but fails
   e. The timeline protects faculty (and the student) from dragging on ineffective remediation unnecessarily.
4. Faculty are encouraged to candidly evaluate a student’s performance and to dismiss a student when dismissal is warranted.
   a. Disciplinary dismissal
      i. Determination of facts results from allegations of misconduct and/or violation of rules.
      ii. Due process is by formal hearing.
         a) includes depositions, witnesses, crossexamination, presentation of evidence
      iii. Burden of proof is on the academic institution.
         a) must show that due process was provided and that sanctions were appropriate
   b. Academic dismissal
      i. Determination of facts is by professional judgment.
         a) cognitive assessment
         b) noncognitive/clinical performance evaluation
      ii. Due process is informal.
         a) notice of inadequacies and opportunity to improve
         b) careful and deliberate decision making based on entire academic record
         c) informal meeting/discussion
      iii. Burden of proof is on the student.
         a) must show action to be arbitrary or capricious
         b) must show some other error in decisionmaking process
   c. Defamation alleged from evaluations
      i. Written defamation is libel.
      ii. Spoken defamation slander.
      iii. To avoid libel charges the following must be met.
         a) candid evaluations made in good faith
         b) made on firsthand information vs reported information
         c) not communicated to third parties outside of the academic program
         d) not made with malicious intent
      iv. Refer to Buckley Amendment to the Family Rights and Privacy Act — 1974.
      v. Refer to Health Insurance Portability and Accountability Act (HIPAA) — 1996. For more information about HIPAA refer to:
         a) http://www.hhs.gov/ocr/privacy/
         b) http://www.apta.org/HIPAA/
      vi. Patient's/Client's Rights (HIPAA): care provisions and clinical education
   d. Memorandum of agreement (see below)
   e. Summary of legal responsibilities
      i. The rules governing the student’s performance must be communicated to the student prior to evaluation on that performance.
      ii. The student must be treated fairly and given feedback regarding his or her performance.
      iii. The clinical instructors must show that they have not acted arbitrarily or capriciously.
      iv. The problemsolving process should be documented, as should the student's behavior and response to feedback.
      v. The ACCE/DCE, CCCE, CI, and student should all be involved in any contract negotiations and decision making.
      vi. Patients must be informed of and consent to health care services prior to delivery, especially in the case of services provided by students.
MEMORANDUM OF AGREEMENT

“I have read and understood the contents of the following:

[NAME OF DOCUMENTS OR HANDBOOK HERE]

I agree to abide by the policies and procedures stated in the above listed materials."

________________________________________  ________________________
Student’s Name (Printed)  Date

Student’s Signature  Date

CI/CCCE Signature  Date
C. Students With Disabilities

The Case of a Student With a Disability
A student is beginning his second (of 4) clinical experiences at an outpatient orthopedic facility after completing 1/2 of a 3-year DPT program. He has successfully passed all classroom coursework to date. His first 4-week clinical experience was in home health care. The student is provided with an orientation on the first day of the experience with clear weekly expectations set for his performance. The student identifies learning objectives and performance areas that he believes are his strengths and limitations. The Weekly Planning Form is completed for the first week that describes the learning objectives he is expected to achieve.

Week 1
- The student becomes flustered when trying to manage situations that require multitasking (eg, checking on a patient completing exercises, setting up another patient on an exercise program, and completing patient documentation in 30 minutes).
- Under stressful situations, the student is unable to control his emotions and may interact with patients inappropriately or lash out at another clinician. When the student is able to complete single tasks at a time, his behavior appears manageable.
- The student becomes defensive and unable to converse when questioned directly about how he arrived at a diagnosis.
- The student is easily distracted in a gym setting with difficulty focusing on the patient.

Week 2
- Beginning the second week, the CI sits in a quiet area to talk with the student about his performance. The CI asks “How do you think you are doing?” The student responds he is doing fine and just needs to work on his time management skills so that multiple activities do not occur simultaneously.
- The CI is concerned with the student’s self-assessment and wonders if something more is going on with this student that is not readily evident.
- The CI further questions the student regarding whether similar situations have happened before. The student denies that this situation has happened before and indicates he just needs more time to accommodate to this clinical environment.
- Learning objectives are set up for the student for the next 2 weeks using some of the sample behaviors from the CPI to focus his ability to multitask, to stay attentive on the care being provided to the patient, and to interact appropriately with patients and others.

Week 3
- The student continues to have distractibility problems that appear to be getting worse.
- Episodes continue with raised voices to patients during multitasking situations.
- Errors continue in patient documentation, even within a more structured and controlled learning environment.
- “Significant at-risk” performance is demonstrated on several of the “red flag” items on the CPI. The CI suspects the student has other significant problems.
- The CI asks the student directly if there is anything else that the CI ought to know that would explain his continued performance deficits. The student admits that he does have a known learning disability that has been disclosed only to the academic program. He believed that disclosure of a disability to the CI or CCCE would not be necessary for him to successfully complete the clinical experience. He had not had any prior difficulty in academic or clinical situations and thought he could compensate for his disability. The pace and nature of this clinical environment, however, has made it difficult for him to successfully manage and control his environment.
- The CI recognizes that the student has now disclosed a known learning disability while on this clinical experience.
1. **Purpose of the Americans With Disabilities Act (ADA)**  
   To provide “clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.”

2. **Proof of Disability**  
   “A physical or mental impairment that substantially limits one or more of the major life activities of an individual.”

3. **Proof of Discrimination**  
   Failure to “make reasonable accommodations to known physical or mental limitations.”  
   Plaintiff shows:  
   a. that he or she is disabled  
   b. that his or her requests for accommodation are reasonable  
   c. that those requests have been denied

4. **There are several other important components to include or consider with respect to the ADA.**  
   a. The academic program and the clinical facility should identify in writing the essential functions and technical skills required to perform specific tasks or hold the position of the profession (eg, PT, OT, SLP, and pharmacy). These essential functions should address cognitive, psychomotor, and affective components.7-9  
   b. Academic and clinical faculties, with the student, must determine whether or not the student with reasonable accommodations can meet the essential functions.  
   c. The student must still meet the required performance competencies and essential functions for entry into practice and the profession. Accommodations allow the student to modify the manner and timeframe for meeting the competencies; however, they do not permit the student to matriculate into or graduate from the academic program if the established competencies are not met.10-11
### D. Student Supervisory Issues

*Note: Please refer to the APTA website for the most current information, as these may change:*
- federal and state regulatory standards ([http://www.apta.org/Payment/](http://www.apta.org/Payment/))
- practice acts ([www.fsbpt.org](http://www.fsbpt.org))
- licensure information ([http://www.apta.org/Licensure/](http://www.apta.org/Licensure/))

#### Student Supervisory Issues Affected by Regulations and APTA Policies and Positions

<table>
<thead>
<tr>
<th>Federal Law</th>
<th>State Law</th>
<th>Regulatory Agency</th>
<th>Payer</th>
<th>Employer</th>
<th>APTA/Best Practice (includes patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare (student supervision; requirements of PTAs)</td>
<td>Practice Acts</td>
<td>Joint Commission</td>
<td>Government</td>
<td>Policies</td>
<td>Positions</td>
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<tr>
<td>Medicaid</td>
<td></td>
<td>CARF</td>
<td>Private</td>
<td>Mission Statements</td>
<td>Policies</td>
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<tr>
<td>HIPAA</td>
<td></td>
<td>CORF</td>
<td>Self-Pay</td>
<td>Standards</td>
<td>Guidelines</td>
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<tr>
<td>Patient Bill of Rights</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Activity 1
Student Supervision, Billing and Documentation for Medicare Part A

An 85-year-old white female is admitted to a SNF in your state for physical therapy after a 3-day qualifying stay at Bethany Nursing Home for a CVA on the left side. She is eligible for skilled benefits under Medicare Part A. She is diagnosed by a physical therapist with impaired motor function and sensory integrity associated with acquired nonprogressive disorders of the central nervous system in adulthood (Neuromuscular – Pattern B). The plan of care provides for interventions including patient/client instruction, ADL training (bed mobility and transfer training, gait training), neuromuscular reeducation, balance and coordination training, and motor function retraining. Department staff includes 10 physical therapists, 4 physical therapist assistants, 2 physical therapist students, and 2 physical therapist assistant students. As the supervising therapist you must decide how to properly provide this patient’s care by directing and supervising the PT and PTA students according to the state practice act, Medicare Part-A regulations, and APTA guidelines, policies, and positions.

1. What can the PT student perform in this situation? How should he or she be supervised? What can be billed? How should the supervising PT handle patient care documentation provided by the PT student? Support your position.

2. What can the PTA student perform in this situation? How should he or she be supervised? What can be billed? How should the supervising PT handle patient care documentation provided by the PTA student? Support your position.

(See answer key in Section VII.)
Activity 2

Student Supervision, Billing and Documentation for Medicare Part B

A 66-year-old Hispanic male is being seen in an outpatient orthopedic clinic s/p rotator cuff repair surgery on the left (dominant). The patient is also diabetic. He is diagnosed by a physical therapist with impaired joint mobility, motor function, muscle performance, and range of motion associated with soft tissue surgery (Musculoskeletal - Pattern I). He also complains of mild postsurgical pain and tenderness over the incision for which he takes extra-strength Tylenol. He is eligible for benefits under Medicare Part B. The physical therapist plan of care indicates interventions including joint mobilization, connective tissue massage, stretching, therapeutic exercise, and cryotherapy. Physical therapy department staff includes 6 physical therapists, 2 physical therapist assistants, 1 physical therapist student and 1 physical therapist assistant student. As the supervising therapist you must decide how to properly provide care by directing and supervising the PTA clinician, PT student, and PTA student according to your state practice act, Medicare Part B regulations, and APTA guidelines, policies, and positions. In addition, the student has some strong indicators that this outpatient clinic may be benefiting from a referral-for-profit situation.

1. What can the PT student perform in this situation? How should he or she be supervised? What can be billed? How should the supervising PT handle patient care documentation provided by the PT student? Support your position.

2. What can the PTA student perform in this situation? How should he or she be supervised? What can be billed? How should the supervising PT handle patient care documentation provided by the PTA student? Support your position.

3. What should students do if they find themselves in a clinical education facility that may be engaged in a referral-for-profit situation?

(See answer key in Section VII.)
Supervision of Students Under Medicare (chart)¹²
(Last updated: 12/12/2011)

<table>
<thead>
<tr>
<th>Practice Setting</th>
<th>PT Student</th>
<th></th>
<th>PTA Student</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapist in Private Practice</td>
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<td>X¹</td>
<td>N/A</td>
<td>X¹</td>
</tr>
<tr>
<td>Certified Rehabilitation Agency</td>
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<td>X¹</td>
<td>N/A</td>
<td>X¹</td>
</tr>
<tr>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
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<td>X¹</td>
<td>N/A</td>
<td>X¹</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
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<td>X¹</td>
<td>Y²</td>
<td>X¹</td>
</tr>
<tr>
<td>Hospital</td>
<td>Y³</td>
<td>X¹</td>
<td>Y³</td>
<td>X¹</td>
</tr>
<tr>
<td>Home Health Agency</td>
<td>NAR</td>
<td>X¹</td>
<td>NAR</td>
<td>X¹</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facility</td>
<td>Y⁴</td>
<td>N/A</td>
<td>Y⁴</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Key:**

Y: Reimbursable  
N/A: Not Applicable  
X: Not Reimbursable  
NAR: Not Addressed in Regulation. Please defer to state law.

Contact: advocacy@apta.org

**Y¹:** Reimbursable: Therapy students are not required to be in line-of-sight of the professional supervising therapist/assistant **(Federal Register**, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. Additionally all state and professional practice guidelines for student supervision must be followed. Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy. All time that the student spends with patients should be documented.

Medicare Part B—The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:

- The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician’s service, not for the student’s services.) **(RAI Version 3.0 Manual, October 2011).**

**Individual Therapy**

When a therapy student is involved with the treatment of a resident, the minutes may be coded as individual therapy when only one resident is being treated by the therapy student and supervising therapist/assistant (Medicare A and Medicare B). The supervising therapist/assistant shall not be engaged in any other activity or treatment when the resident is receiving therapy under Medicare B. However, for those residents whose stay is covered under Medicare A, the supervising therapist/assistant shall not be treating or supervising other individuals and he/she is able to immediately intervene/assist the student as needed.

**Example:** A speech therapy graduate student treats Mr. A for 30 minutes. Mr. A.’s therapy is covered under the Medicare Part A benefit. The supervising speech-language pathologist is not treating any patients at this time but is not in the room with the student or Mr. A. Mr. A.’s therapy may be coded as 30 minutes of individual therapy on the MDS.
Concurrent Therapy
When a therapy student is involved with the treatment, and one of the following occurs, the minutes may be coded as concurrent therapy:

- The therapy student is treating one resident and the supervising therapist/assistant is treating another resident, and both residents are in line of sight of the therapist/assistant or student providing their therapy; or
- The therapy student is treating 2 residents, regardless of payer source, both of whom are in line-of-sight of the therapy student, and the therapist is not treating any residents and not supervising other individuals; or
- The therapy student is not treating any residents and the supervising therapist/assistant is treating 2 residents at the same time, regardless of payer source, both of whom are in line-of-sight.

Medicare Part B: The treatment of two or more residents who may or may not be performing the same or similar activity, regardless of payer source, at the same time is documented as group treatment.

Example: An Occupational Therapist provides therapy to Mr. K. for 60 minutes. An occupational therapy graduate student, who is supervised by the occupational therapist, is treating Mr. R. at the same time for the same 60 minutes but Mr. K. and Mr. R. are not doing the same or similar activities. Both Mr. K. and Mr. R’s stays are covered under the Medicare Part A benefit. Based on the information above, the therapist would code each individual’s MDS for this day of treatment as follows:

Mr K. received concurrent therapy for 60 minutes. Mr R. received concurrent therapy for 60 minutes.

Group Therapy
When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing the group treatment and the supervising therapist/assistant is not treating any residents and is not supervising other individuals (students or residents); or
- The supervising therapist/assistant is providing the group treatment and the therapy student is not providing treatment to any resident. In this case, the student is simply assisting the supervising therapist.

Medicare Part B: The treatment of 2 or more individuals simultaneously, regardless of payer source, who may or may not be performing the same activity.

When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing group treatment and the supervising therapist/assistant is not engaged in any other activity or treatment; or
- The supervising therapist/assistant is providing group treatment and the therapy student is not providing treatment to any resident.

Documentation: APTA recommends that the physical therapist co-sign the note of the physical therapist student and state the level of supervision that the PT determined was appropriate for the student and how/if the therapist was involved in the patient’s care.

Y²: Reimbursable: The minutes of student services count on the Minimum Data Set. Medicare no longer requires that the PT/PTA provide line-of-sight supervision of physical therapist assistant (PTA) student services. Rather, the supervising PT/PTA now has the authority to determine the appropriate level of supervision for the student, as appropriate within their state scope of practice. See Y¹.

Documentation: APTA recommends that the physical therapist and assistant should co-sign the note of physical therapist assistant student and state the level of appropriate supervision used. Also, the documentation should reflect the requirements as indicated for individual therapy, concurrent therapy, and group therapy in Y¹.
### X1: B. Therapy Students

1. **General**
   
   Only the services of the therapist can be billed and paid under Medicare Part B. The services performed by a student are not reimbursed even if provided under “line of sight” supervision of the therapist; however, the presence of the student “in the room” does not make the service unbillable.

   **Examples:**
   Therapists may bill and be paid for the provision of services in the following scenarios:
   - The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
   - The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.
   - The qualified practitioner is responsible for the services and as such, signs all documentation. (A student, of course, also sign but it is not necessary since the Part B payment is for the clinician’s service, not for the student’s services).

2. **Therapy Assistants as Clinical Instructors**
   
   Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

   Documentation: APTA recommends that the physical therapist or physical therapist assistant complete documentation.
Implementing MDS 3.0: Use of Therapy Students

As facilities continue to change their current practices to implement the Minimum Data Set Version 3.0 (better known as MDS 3.0), one of the emerging issues is the manner in which they document and utilize therapy students. Under the new rules, in order to record the minutes as individual therapy when a therapy student is involved in the treatment of a resident, only one resident can be treated by the therapy student and the supervising therapist or assistant (for Medicare Part A and Part B). In addition, the supervising therapist or assistant cannot engage in any other activity or treatment when the resident is receiving treatment under Medicare Part B. However, for those residents whose stay is covered under Medicare Part A, the supervising therapist or assistant cannot be treating or supervising other individuals. Beginning on October 1, 2011, the student and resident no longer need to be within the line-of-sight supervision of the supervising therapist. CMS will allow the supervising therapist to determine the appropriate level of supervision for the student. The student is still treated as an extension of the therapist, and the time the student spends with the patient will continue to be billed as if the supervising therapist alone was providing the services.

Under Medicare Part A, when a therapy student is involved with the treatment, and one of the following occurs, the minutes may be coded as concurrent therapy:

- The therapy student is treating one resident and the supervising therapist or assistant is treating another resident and the therapy student is supervised by the therapist at the appropriate level of supervision as determined by the supervising therapist; or
- The therapy student is treating two residents at the appropriate level of supervision as determined by the supervising therapist and the therapist is not treating any residents and not supervising other individuals; or
- The therapy student is not treating any residents and the supervising therapist or assistant is treating two residents at the same time, regardless of payer source

The student would be precluded from treating the resident and recording the minutes as concurrent therapy under Medicare Part B.

Under Medicare Part A, when a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing the group treatment at the appropriate level of supervision as determined by the supervising therapist and the supervising therapist or assistant is not treating any residents and is not supervising other individuals (students or residents); or
- The supervising therapist/assistant is providing the group treatment and the therapy student is not providing treatment to any resident.

Under Medicare Part B, when a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing group treatment and the supervising therapist or assistant is present and in the room and is not engaged in any other activity or treatment; or
- The supervising therapist or assistant is providing group treatment and the therapy student is not providing treatment to any resident.
USE OF STUDENTS UNDER MEDICARE PART B

The purpose of this document is to provide clarification on the circumstances under which physical therapy students may participate in the provision of outpatient therapy services to Medicare patients, and whether or not such services are billable under Medicare Part B. Specifically, this document addresses student participation in the provision of services in the following settings: private practice physical therapy offices, rehabilitation agencies, comprehensive outpatient rehabilitation facilities (CORFs), skilled nursing facilities (SNFs) (Part B), outpatient hospital departments, and home health agencies (Part B).

Background
CMS issued a program memorandum, (AB-01-56) on the provision of outpatient therapy services by therapy students on April 11, 2001. In this program memorandum (http://www.cms.hhs.gov/Transmittals/downloads/AB0156.pdf), CMS provided answers to frequently asked questions regarding payment for the services of therapy students under Part B of the Medicare program.

In response to inquiries from the American Speech Language Hearing Association (ASHA), CMS issued a follow-up letter dated November 9, 2001, to ASHA in which they further clarified the policy on payment of student services that they outlined in the Q and A program memorandum. On January 10, 2002 CMS also issued a similar letter to AOTA on the subject. The follow-up letters to ASHA and AOTA were not intended to signify a change in the policy issued in the program memorandum; they were merely intended to provide further clarification.

Specifically, in the program memorandum (AB-01-56), CMS stated, in part, that “services performed by a student are not reimbursed under Medicare Part B. Medicare pays for services of physicians and practitioners (eg, licensed physical therapists) authorized by statute. Students do not meet the definition of practitioners listed in the statute.” Regarding whether services provided by the student with the supervising therapist “in the room” can be reimbursed, CMS stated that “Only the services of the therapist can be billed to Medicare and be paid. However, the fact that the student is ‘in the room’ would not make the service unbillable. Medicare would pay for the services of the therapist.” In response to another question, CMS stated that “the therapist can bill for the direct services he/she provides to patients under Medicare Part B. Services performed by the therapy student are not payable under Medicare Part B.”

In the letter to ASHA, CMS once again stated that in order to be paid Medicare Part B services must be provided by practitioners who are acting within the scope of their state licensure. CMS further described circumstances under which it considers the service as being essentially provided directly by the qualified practitioner, even though the student has some involvement. Such services would be billable. Specifically, CMS states:

“"The qualified practitioner is recognized by the Medicare Part B beneficiary as the responsible professional within any session when services are delivered."

“The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.”

“The qualified practitioner is present in the room, guiding the student in service delivery when the student is participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.”

“The qualified practitioner is responsible for the services and as such, signs all documentation (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician’s services, not for the student’s services).”

In response to a request from AOTA, CMS issued a summary of its understanding of the typical scenario involving students for which occupational therapists seek payment. The information provided in this letter mirrors what was stated in the letter provided to ASHA.
Acceptable Billing Practices
Based on the information provided by CMS and MedPAC, it is possible for a physical therapist to bill for services only when the services are furnished jointly by the physical therapist and student. APTA recommends that physical therapists consider the following factors in determining whether or not a physical therapist may bill Medicare Part B for a service when the therapy student is participating in the provision of the service.

- Physical therapists should use their professional judgment on whether or not a service is billable, keeping in mind the importance of integrity when billing for services.

- Physical therapists should distinguish between the ability of a student to provide services to a patient/client from the ability to bill for student services provided to Medicare Part B patients. A student may provide services to any patient/client provided it is allowable by state law. This does not mean, however, that the services provided by the student are billable to Medicare, Medicaid, or private insurance companies.

- As CMS states, only services provided by the licensed physical therapist can be billed to Medicare for payment. Physical therapists should consider whether the service is being essentially provided directly by the physical therapist, even though the student has some involvement in providing the care. In making this determination, the therapist should consider how closely involved he or she is in providing the patient’s care when a student is participating. The therapist should be completely and actively engaged in providing the care of the patient. As CMS states in its letter, “the qualified practitioner is present in the room, guiding the student in service delivery when the student is participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.” The therapist should direct the service, make the skilled judgment, and be responsible for the assessment and treatment. There should be checks and balances provided by the physical therapist throughout the entire time the patient/client is being managed.

- The physical therapist should ask himself or herself whether the billing would be the same whether or not there is a student involved. The therapist should not bill beyond what he or she would normally bill in the course of managing that patient’s care. The individual therapist or the employer should not benefit financially from having the student involved in the clinical experience in the practice or facility.

Conclusion
It is crucial that physical therapists be aware of and comply with Medicare regulations governing the circumstances in which physical therapy students may participate in the provision of physical therapy services. CMS has clearly stated its policy that student services under Part B are not billable, and that only services provided to Medicare beneficiaries by the PT may be billed. APTA will continue to work to ensure that physical therapy students receive the clinical training they need in order to provide valuable, high-quality physical therapy services to patients/clients.

(Last Updated: 4/7/2011)
USE OF PHYSICAL THERAPIST ASSISTANTS (PTAs) UNDER MEDICARE

Please note that physical therapists are licensed providers in all states and physical therapist assistants are licensed providers in the majority of states. As licensed providers, the state practice act governs supervision requirements. Some state practice acts mandate more stringent supervision standards than Medicare laws and regulations. In those cases, the physical therapist and physical therapist assistants must comply with their state practice act. For example, in a skilled nursing facility in New Jersey, a physical therapist must be on the premises when services are furnished by a physical therapist assistant despite the fact that Medicare requires general supervision. New Jersey’s state practice act requires direct supervision rather than general supervision, and therefore, the physical therapist and physical therapist assistant would have to comply with this requirement.

Certified Rehabilitation Agency (CRA)
CRAs are required to have qualified personnel provide initial direction and periodic observation of the actual performance of the function and/or activity. If the person providing services does not meet the assistant-level practitioner qualifications in 485.705, then the physical therapist must be on the premises.

Comprehensive Outpatient Rehabilitation Facility (CORF)
The services must be furnished by qualified personnel. If the personnel do not meet the qualifications in 485.705, then the qualified staff must be on the premises and must instruct these personnel in appropriate patient care service, techniques, and retain responsibility for their activities. A qualified professional representing each service made available at the facility must be either on the premises of the facility or must be available through direct telecommunications for consultation and assistance during the facility’s operating hours.

Home Health Agencies (HHA)
Physical therapy services must be performed safely and/or effectively only by or under the general supervision of a skilled therapist. General supervision has been traditional described in HCFA manuals as requiring the initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

Inpatient Hospital Services
Physical therapy services must be those services that can be safely and effectively performed only by or under the supervision of a qualified physical therapist. Because the regulations do not specifically delineate the type of direction required, the provider must defer to his or her physical therapy state practice act.

Outpatient Hospital Services
Physical therapy services must be those services that can be safely and effectively performed only by or under the supervision of a qualified physical therapist. Because the regulations do not specifically delineate the type of direction required, the provider must defer to his or her physical therapy state practice act.

Private Practice
Physical therapy services must be provided by or under the direct supervision of the physical therapist in private practice. CMS has generally defined direct supervision to mean that the supervising private practice therapist must be present in the office suite at the time the service is performed.

Physician’s Office
Services must be provided under the direct supervision of a physical therapist who is enrolled as a provider under Medicare. A physician cannot bill for the services provided by a PTA. The services must be billed under the provider number of the supervising physical therapist. CMS has generally defined direct supervision to mean that the physical therapist must be in the office suite when an individual procedure is performed by supportive personnel.

Skilled Nursing Facility (SNF)
Skilled rehabilitation services must be provided directly or under the general supervision of skilled rehabilitation personnel. A General Supervision® is further defined in the manual as requiring the initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.
USE OF PHYSICAL THERAPY AIDES UNDER MEDICARE

Certified Rehabilitation Agency (CRA)
In order for services to be reimbursed under Medicare Part B benefit, they may not be provided by a physical therapy aide regardless of level of supervision.
CMS’s policy is that the therapy aide may assist the professional therapist or therapist assistant to perform a specific therapy service. The aide should never be the provider of the service.

Comprehensive Outpatient Rehabilitation Facility (CORF)
In order for services to be reimbursed under Medicare Part B benefit, they may not be provided by a physical therapy aide, regardless of level of supervision.
CMS’s policy is that the therapy aide may assist the professional therapist or therapist assistant to perform a specific therapy service. The aide should never be the provider of the service.

Home Health Agencies (HHA)
Under Medicare Part A regulations, all therapy services offered by the HHA, either directly or under arrangements, must be provided by a qualified therapist or a qualified therapist assistant under the therapist’s supervision and in accordance with the plan of care. The qualified therapist assists the physician in evaluating level of function, helps develop the plan of care (revising as necessary), prepares clinical and progress notes, advises and consults with the family and other agency personnel, and participates in in-service programs. (42 CFR §484.32)
An HHA that wishes to furnish outpatient physical therapy or speech pathology services must meet all the pertinent conditions of this part and also meet the additional health and safety requirements set forth in subpart H of part 485 of this chapter to implement section 1861(p) of the Act. 42 CFR 484.38

Inpatient Hospital Services
Physical therapy services must be those services that can be safely and effectively performed only by or under the supervision of a qualified physical therapist. According to 42 CFR Section 482.56 of the Medicare hospital conditions of participation, “physical therapy, if provided, must be provided by staff who meet the qualifications specified by medical staff, consistent with state law.” Because the regulations do not specifically delineate the type of direction required, the provider must defer to his or her physical therapy state practice act.

Outpatient Hospital Services
In order for services to be reimbursed under Medicare Part B benefit, they may not be provided by a physical therapy aide regardless of level of supervision.
CMS’s policy is that the therapy aide may assist the professional therapist or therapist assistant to perform a specific therapy service. The aide should never be the provider of the service.

Physical Therapist in Private Practice
In order for services to be reimbursed under Medicare Part B benefit, they may not be provided by a physical therapy aide regardless of level of supervision.
CMS’s policy is that the therapy aide may assist the professional therapist or therapist assistant to perform a specific therapy service. The aide should never be the provider of the service, however, and employees must be personally supervised by the physical therapist.

Physician’s Office / “Incident to” Billing
Effective July 25, 2005, in order for services to be reimbursed under Medicare Part B benefit, they may not be provided by a physical therapy aide, regardless of level of supervision.

Skilled Nursing Facilities
Effective July 30, 1999, “The therapy assistant cannot supervise a therapy aide. It is up to the professional therapist to ensure that the assistant is capable of performing therapy services without the more stringent “line-of-sight” level of supervision required by therapy aides. A therapy aide must be supervised personally by the professional therapist in such a way that the therapist has visual contact with the aide at all times. Therapy aides are not to perform any services without “line-of-sight” supervision. Similarly, a therapy aide must never be responsible for provision of group therapy services, as this is well
beyond the scope of services that they are qualified to provide."
Additionally, the rule states that set-up time, as well as time under the therapist’s direct supervision, count as reportable therapy minutes on the MDS.

**Use of Aides in the Delivery of Skilled Services**
Per the RAI manual instructions released on November 9, 2009, aides cannot be used to deliver skilled services. Aides should be used to provide support services and those services cannot be counted towards the minutes on the MDS. This policy is further detailed in the 2010 SNF PPS Final Rule.
From August 2003 through October 1, 2009, the following policy regarding the use of aides in SNFs was in effect. As of October 1, 2009, this policy is no longer effective.

Supervision (Medicare A only): Aides cannot independently provide a skilled service. The services of aides performing therapy treatments may only be coded when the services are performed under line of sight supervision by a licensed therapist when allowed by state law. This type of coordination between the licensed therapist and therapy aide under the direct, personal (e.g., line of sight) supervision of the therapist is considered individual therapy for counting minutes. When the therapist starts the session and delegates the performance of the therapy treatment to a therapy aide, while maintaining direct line of sight supervision, the total number of minutes of the therapy session may be coded as therapy minutes.
(Last updated 3/6/2011)
Recommended Skilled Nursing Facility Therapy
Student Supervision Guidelines

(Submitted to CMS by the American Physical Therapy Association (APTA)
during the comment period for the FY 2012 SNF PPS Final Rule)

Please note: These suggested guidelines would be in addition to the student supervision guidelines outlined in the RAI
MDS 3.0 Manual and all relevant federal regulations.

• The amount of supervision must be appropriate to the student’s level of knowledge, experience, and competence.
• Students who have been approved by the supervising therapist or assistant to practice independently in selected pa-
tient/client situations can perform those selected patient/client services specified by the supervising therapist/assistant.
• The supervising therapist/assistant must be physically present in the facility and immediately available to provide
observation, guidance, and feedback as needed when the student is providing services.
• When the supervising therapist/assistant has cleared the student to perform medically necessary patient/client
services, and the student provides the appropriate level of services, the services will be counted on the MDS as skilled
therapy minutes.
• The supervising therapist/assistant is required to review and cosign all students’ patient/client documentation for all
levels of clinical experience and retains full responsibility for the care of the patient/client.
• Therapist assistants can provide instruction and supervision to therapist assistant students so long as the therapist as-
sistant is properly supervised by the therapist.

These changes as well as other changes regarding MDS 3.0 will take effect October 1, 2011. If you have questions regarding
this provision or other provisions within MDS 3.0, please contact APTA at advocacy@apta.org or 800/999-2782, ext 8533.

It is the policy of the American Physical Therapy Association (APTA) that:

Protection of the consumer requires that physical therapy services be provided only by, or under the direction and supervision of, duly licensed physical therapists who have successfully completed physical therapist professional education. Physical therapist professional education includes graduates from 1926 to 1959 who have completed physical therapy curricula approved by the appropriate accreditation bodies. It also includes graduates from 1960 to the present who have successfully completed professional physical therapy education programs accredited by the Commission on Accreditation in Physical Therapy Education or determined to be equivalent.

Protection of the consumer further requires that the practice of physical therapists, which includes examination, evaluation, diagnosis, prognosis, and intervention complies with well-defined regulations. In addition, physical therapist assistants, under the direction and supervision of the physical therapist, are the only individuals who assist in the provision of selected physical therapy interventions. The physical therapist assistant is a graduate of a physical therapist assistant program accredited by the Commission on Accreditation in Physical Therapy Education and is licensed or otherwise regulated.

Levels of Supervision (HOD P06-00-15-26)

The American Physical Therapy Association recognizes the following levels of supervision:

General Supervision: The physical therapist is not required to be on-site for direction and supervision, but must be available at least by telecommunications.

Direct Supervision: The physical therapist is physically present and immediately available for direction and supervision. The physical therapist will have direct contact with the patient during each visit that is defined in the Guide to Physical Therapist Practice as all encounters with a patient/client in a twenty-four hour period. Telecommunications does not meet the requirement of direct supervision.

Direct Personal Supervision: The physical therapist, or where allowable by law, the physical therapist assistant, is physically present and immediately available to direct and supervise tasks that are related to patient/client management. The direction and supervision is continuous throughout the time these tasks are performed. Telecommunications does not meet the requirement of direct personal supervision.

Student Physical Therapist Provision of Services (HOD P06-00-18-30)

It is the position of the American Physical Therapy Association (APTA) that:

Student physical therapists, when participating as part of a physical therapist professional education curriculum and when acting in accordance with APTA policy and applicable state laws and regulations, are qualified to provide services only under the direction and direct supervision of the physical therapist, who is responsible for patient/client management. Direct supervision means the physical therapist is physically present and immediately available for direction and supervision. The physical therapist will have direct contact with the patient during each visit that is defined in the Guide to Physical Therapist Practice as all encounters with a patient/client in a twenty-four hour period. Telecommunications does not meet the requirement of direct supervision.
Supervision of Student Physical Therapist Assistants (HOD P06-11-09-17)

It is the position of the American Physical Therapy Association (APTA) that:

Student physical therapist assistants, when participating as part of a physical therapist assistant education curriculum and when acting in accordance with American Physical Therapy Association policy and applicable state laws and regulations, are qualified to perform selected physical therapy interventions under the direction and direct supervision of either the physical therapist alone or the physical therapist and physical therapist assistant working as a team. When the student physical therapist assistant is participating in the delivery of physical therapy services while being supervised by the physical therapist alone or the physical therapist and physical therapist assistant working as a team, the physical therapist or the physical therapist assistant is physically present and immediately available at all times. The physical therapist or the physical therapist assistant will have direct contact with the patient/client during each visit as visit is defined in the Guide to Physical Therapist Practice. The physical therapist maintains responsibility for patient/client management at all times, including appropriate utilization of the physical therapist assistant as described in Direction and Supervision of the Physical Therapist Assistant, and for interventions performed by the student physical therapist assistant.

Direction and Supervision of the Physical Therapist Assistant (HOD P06-05-18-26)

Physical therapists have a responsibility to deliver services in ways that protect the public safety and maximize the availability of their services. They do this through direct delivery of services in conjunction with responsible utilization of physical therapist assistants who assist with selected components of intervention. The physical therapist assistant is the only individual permitted to assist a physical therapist in selected interventions under the direction and supervision of a physical therapist.

Direction and supervision are essential in the provision of quality physical therapy services. The degree of direction and supervision necessary for assuring quality physical therapy services is dependent upon many factors, including the education, experiences, and responsibilities of the parties involved, as well as the organizational structure in which the physical therapy services are provided.

Regardless of the setting in which the physical therapy service is provided, the following responsibilities must be borne solely by the physical therapist:

1. Interpretation of referrals when available.
2. Initial examination, evaluation, diagnosis, and prognosis.
3. Development or modification of a plan of care which is based on the initial examination or reexamination and which includes the physical therapy goals and outcomes.
4. Determination of when the expertise and decision-making capability of the physical therapist requires the physical therapist to personally render physical therapy interventions and when it may be appropriate to utilize the physical therapist assistant. A physical therapist shall determine the most appropriate utilization of the physical therapist assistant that provides for the delivery of service that is safe, effective, and efficient.
5. Reexamination of the patient/client in light of their goals, and revision of the plan of care when indicated.
6. Establishment of the discharge plan and documentation of discharge summary/status.
7. Oversight of all documentation for services rendered to each patient/client.

The physical therapist remains responsible for the physical therapy services provided when the physical therapist’s plan of care involves the physical therapist assistant to assist with selected interventions. Regardless of the setting in which the service is provided, the determination to utilize physical therapist assistants for selected interventions requires the education, expertise, and professional judgment of a physical therapist as described by the Standards of Practice, Guide to Professional Conduct, and Code of Ethics.

In determining the appropriate extent of assistance from the physical therapist assistant (PTA), the physical therapist considers:

- The PTA’s education, training, experience, and skill level.
- Patient client criticality, acuity, stability, and complexity.
- The predictability of the consequences.
- The setting in which the care is being delivered.
- Federal and state statutes.
- Liability and risk management concerns
- The mission of physical therapy services for the setting.
- The needed frequency of reexamination
**Physical Therapist Assistant**

**Definition**
The physical therapist assistant is a technically educated health care provider who assists the physical therapist in the provision of physical therapy. The physical therapist assistant is a graduate of a physical therapist assistant associate degree program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE).

**Utilization**
The physical therapist is directly responsible for the actions of the physical therapist assistant related to patient/client management. The physical therapist assistant may perform selected physical therapy interventions under the direction and at least general supervision of the physical therapist. In general supervision, the physical therapist is not required to be on-site for direction and supervision, but must be available at least by telecommunications. The ability of the physical therapist assistant to perform the selected interventions as directed shall be assessed on an ongoing basis by the supervising physical therapist. The physical therapist assistant makes modifications to selected interventions either to progress the patient/client as directed by the physical therapist or to ensure patient/client safety and comfort.

The physical therapist assistant must work under the direction and at least general supervision of the physical therapist. In all practice settings, the performance of selected interventions by the physical therapist assistant must be consistent with safe and legal physical therapist practice, and shall be predicated on the following factors: complexity and acuity of the patient’s/client’s needs; proximity and accessibility to the physical therapist; supervision available in the event of emergencies or critical events; and type of setting in which the service is provided.

When supervising the physical therapist assistant in any off-site setting, the following requirements must be observed:
1. A physical therapist must be accessible by telecommunications to the physical therapist assistant at all times while the physical therapist assistant is treating patients/clients.
2. There must be regularly scheduled and documented conferences with the physical therapist assistant regarding patients/clients, the frequency of which is determined by the needs of the patient/client and the needs of the physical therapist assistant.
3. In those situations in which a physical therapist assistant is involved in the care of a patient/client, a supervisory visit by the physical therapist will be made:
   a. Upon the physical therapist assistant’s request for a reexamination, when a change in the plan of care is needed, prior to any planned discharge, and in response to a change in the patient’s/client’s medical status.
   b. At least once a month, or at a higher frequency when established by the physical therapist, in accordance with the needs of the patient/client.
   c. A supervisory visit should include:
      i. An on-site reexamination of the patient/client.
      ii. On-site review of the plan of care with appropriate revision or termination.
      iii. Evaluation of need and recommendation for utilization of outside resources.

**Provision of Physical Therapy Interventions and Related Tasks (HOD P06-00-17-28)**

*It is the position of the American Physical Therapy Association (APTA) that:*

Physical therapists are the only professionals who provide physical therapy interventions. Physical therapist assistants are the only individuals who provide selected physical therapy interventions under the direction and at least general supervision of the physical therapist.

Physical therapy aides are any support personnel who perform designated tasks related to the operation of the physical therapy service. Tasks are those activities that do not require the clinical decision making of the physical therapist or the clinical problem solving of the physical therapist assistant. Tasks related to patient/client management must be assigned to the physical therapy aide by the physical therapist, or where allowable by law, the physical therapist assistant, and may only be performed by the aide under direct personal supervision of the physical therapist, or where allowable by law, the physical therapist assistant. Direct personal supervision requires that the physical therapist, or where allowable by law, the physical therapist assistant, be physically present and immediately available to direct and supervise tasks that are related to patient/client management. The direction and supervision is continuous throughout the time these tasks are performed. The physical therapist or physical therapist assistant must have direct contact with the patient/client during each session. Telecommunications does not meet the requirement of direct personal supervision.
Procedural Interventions Exclusively Performed by Physical Therapists (HOD P06-00-30-36)
The physical therapist's scope of practice as defined by the Guide to Physical Therapist Practice includes interventions performed by physical therapists. These interventions include procedures performed exclusively by physical therapists and selected procedures that can be performed by the physical therapist assistant under the direction and supervision of the physical therapist. Procedures that require immediate and continuous examination and evaluation throughout the intervention are performed exclusively by the physical therapist. Such direct interventions within the scope of physical therapist practice that are performed exclusively by the physical therapist include, but are not limited to, spinal and peripheral joint mobilization/manipulation, which are components of manual therapy, and selective sharp debridement, which is a component of wound management.

Documentation Authority for Physical Therapy Services (HOD P05-07-09-03)
Physical therapy examination, evaluation, diagnosis, prognosis, and plan of care (including interventions) shall be documented, dated, and authenticated by the physical therapist who performs the service. Interventions provided by the physical therapist or selected interventions provided by the physical therapist assistant under the direction and supervision of the physical therapist are documented, dated, and authenticated by the physical therapist or, when permissible by law, the physical therapist assistant.

Other notations or flow charts are considered a component of the documented record but do not meet the requirements of documentation in or of themselves.

Students in physical therapist or physical therapist assistant programs may document when the record is additionally authenticated by the physical therapist or, when permissible by law, documentation by physical therapist assistant students may be authenticated by a physical therapist assistant.

Distinction Between the Physical Therapist and the Physical Therapist Assistant in Physical Therapy (HOD P06-01-18-19)
It is the position of the American Physical Therapy Association (APTA) that:

The American Physical Therapy Association (APTA) is committed to promoting the physical therapist as the professional practitioner of physical therapy and promoting the physical therapist assistant as the only individual who assists the physical therapist in the provision of selected physical therapy interventions. The APTA is further committed to incorporating this concept into all Association policies, positions and program activities, wherever applicable.

Professional: The term, “professional,” when used in reference to physical therapy services, denotes the physical therapist.

Physical Therapist Assistant: The physical therapist assistant is an educated individual who works under the direction and supervision of a physical therapist. The physical therapist assistant is the only individual who assists the physical therapist in accordance with APTA's policies and positions in the delivery of selected physical therapy interventions. The physical therapist assistant is a graduate of a physical therapist assistant education program accredited by the Commission on Accreditation in Physical Therapy Education.

Practice: The practice of physical therapy is conducted by the physical therapist.

Ethical and Legal Considerations for Clinical Education (HOD P06-01-16-18)
It is the policy of the American Physical Therapy Association (APTA) that:

Physical therapists, physical therapist assistants, and academic programs shall provide clinical education that reflects, supports, and promotes professional development, complies with legal and ethical standards for patient/client management, and is consistent with the policies and positions of the American Physical Therapy Association. Physical therapist and physical therapist assistant students are obligated to communicate information to their academic program regarding clinical education experiences that appear to be in conflict with these standards, policies, and positions.

Financial Considerations In Practice (HOD P06-99-13-17)
It is the policy of the American Physical Therapy Association (APTA) that:
The American Physical Therapy Association opposes participation in underutilization or overutilization of services for personal or institutional gain, or participation in services that is in any way linked to the financial gain of the referral source.
1. Milam S. *Legal Context for Evaluating and Dismissing Physical Therapy Students*. Senior Counsel and Assistant Attorney General, Health Sciences and Medical Centers, University of Washington, Seattle, WA. Invited presentation, Combined Sections Meeting, American Physical Therapy Association; New Orleans, La; February 1993.


INTERNET RESOURCES

AAPC
http://www.aapc.com/

American Health Information Management Association
http://www.ahima.org/

American Medical Association
www.ama-assn.org/

American Physical Therapy Association Payment Resources
http://www.apta.org/Payment/

Buckley Amendment: Family Educational Right to Privacy Act (FERPA)
http://epic.org/privacy/education/ferpa.html/

Centers for Medicaid and Medicare Services (CMS)
http://www.cms.gov/

Centers for Medicare and Medicaid Services HIPAA Page
https://www.cms.gov/hipaageninfo/

Centers for Medicare and Medicaid Services Regulations, Guidance, and Standards
http://www.cms.gov/home/regsguidance.asp/

Department of Health and Human Services
http://www.hhs.gov/

Department of Health and Human Services Office for Civil Rights
http://www.hhs.gov/ocr/

Guidance on Privacy Rule Priorities From the HHS Office of Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html

Health Data Management
http://healthdatamanagement.com/

Legislative Information
http://thomas.loc.gov/home/thomas.php

Medicaid HIPAA Compliant Concept Model
http://mhhccm.org/

National Committee on Vital and Health Statistics
http://ncvhs.hhs.gov/

Strategic National Implementation Process (SNIP)
http://snip.wedi.org/

Supervision Under Medicare
http://www.apta.org/Payment/Medicare/Supervision/

The American Disabilities Act (P.L. 101-336)
http://www.apta.org/ADA/

TRACE Resources and Tools
http://trace.wisc.edu/resources/
SECTION VI

MANAGING THE EXCEPTIONAL STUDENT IN CLINICAL EDUCATION
SECTION V
MANAGING THE EXCEPTIONAL STUDENT
AND THE STUDENT WITH PROBLEMS
IN CLINICAL EDUCATION

Introduction
The previous sections instruct how to make a general plan for clinical education, individualizing that plan for your student, and evaluating that student. Section VI prepares you to recognize and work effectively with the student who is exceptional in the clinic, considering not only the student whose performance is lower than expected, but also the student whose performance exceeds expectations. Section VI examines ways to identify the exceptional student and the methods for working effectively with that student.

Objectives
Following the completion of this section, you will be able to:

1. Generate appropriate solutions after analyzing a given learning situation.
2. Use a structure or format to sequence the design of learning experiences and to address the problem behavior appropriately.
3. Use communication and conflict management skills to work effectively with the exceptional student.
4. Analyze the effectiveness of the implemented solution.
5. Amend or adapt the planned solution to meet the needs of the learner.

Assumptions

1. The eventual manifestation of problem behaviors can be anticipated through careful and early observation of the student’s performance.
2. An organized, structured approach is the most effective way to identify and manage students who manifest behaviors that are inconsistent with effective clinical practice. Management of exceptional learning experiences is most effective when it includes skilled clinical teaching, judicious selection of learning experiences, and effective use of communication skills.
3. The learning plan applied in an exceptional learning situation should be reassessed to evaluate its effectiveness.
4. The CI can make recommendations to the academic coordinator of clinical education/director of clinical education (ACCE/DCE) regarding the student’s level of performance in the clinical setting.
A. Identification of the Exceptional Student

1. Define “exceptional student”
   An exceptional student performs either above or below expected levels in cognitive, psychomotor, and affective domains.

2. Observe carefully and note the student’s level of performance
   a. Note any unusual or unexpected level (higher or lower) of performance.
   b. Note any indication of the student’s performance that does not match your expectations for demonstrating:
      i. safe and effective practice
      ii. a level of independence appropriate for your facility
      iii. a level of competence consistent with the student’s educational preparation

3. Observe and note the student’s level of learning
   a. If the level of learning is higher than expected, the student will move more quickly through the behavioral objectives.
   b. If level of learning is lower than expected, the student will require smaller steps in his/her progression of learning experiences to successfully meet the behavioral objectives.

4. Diagnose student professional behaviors
   In a study conducted by Hayes, Huber, Rogers, and Sanders,2 the authors found that . . .
   a. Behaviors deemed as “questionable” by supervising clinical instructors fell into 1 of 3 categories:
      i. Inadequate knowledge and skills (cognitive behaviors)
      ii. Poor communication (noncognitive behaviors)
      iii. Unprofessional behavior (noncognitive behaviors)
   b. Conclusion:
      i. More than one-half of unacceptable behaviors were noncognitive; however, cognitive behaviors were addressed more by CIs.
      ii. Students who did not receive feedback about their behavior(s) were unlikely to change.
      iii. Behaviors that changed were associated with a successful clinical experience.
      iv. Cognitive behaviors were used more often by CIs to recommend a negative outcome for the clinical experience.

5. Observe and note the student’s level of performance in each domain of learning
   a. Be prepared for different levels (within the taxonomy) of performance in the cognitive, psychomotor, and affective domains.
   b. A student who performs at a level higher than expected in the cognitive domain could concurrently perform at a level lower than expected in the affective domain.

6. Consider the student’s performance with respect to the expectations of the facility
   a. What is the student’s previous clinical experience (type and number)?
   b. What is the student’s level of academic preparation?
   c. What are the demands of the facility or clinical rotation?

7. Consider the student’s performance with respect to the academic program’s expectations
   a. Refer to the academic program’s midterm and final evaluation expectations as guidelines.
   b. Refer to behavioral objectives in syllabus and letter to CCCE/CI from program; consult with ACCE/DCE.

8. Communicate with the academic program and contact the ACCE/DCE.
   a. Consider using a formative evaluation instrument early in the clinical experience to provide a more detailed picture of the student’s performance.
9. Use evaluation instruments to develop a portfolio of examples
   a. Formative Evaluation Instruments
      i. Weekly Planning Form
      ii. Anecdotal Record
      iii. Critical Incident Report
      iv. Journal
      v. Professional Behaviors Assessment
   b. Summative Performance Evaluation Instruments
      i. APTA Clinical Performance Instruments
      ii. Professional Behaviors Assessment
      iii. Program- or consortium-specific instrument
      iv. Other profession’s summative instruments

B. Working With the Exceptional Student

1. Special Attention to the Learning Environment
   a. Use observation, questioning, and listening skills to understand the student’s point of view
      i. Student’s perception of expectations for this clinical experience
      ii. Previous experiences
      iii. Personal goals and objectives for this clinical experience
      iv. These goals may be negotiated with the student. In the case of the student who is performing beyond expectations, this may include exposure to areas of practice or skills that would be beyond “entry-level” performance.
   b. Maintain unconditional positive regard
      i. Keep an open mind for explanations/motivations
      ii. Focus on the behavior, not the person
      iii. Develop ways to work together

2. Specialized Communication Skills
   The following strategies may prove effective when confronting the student who is demonstrating clinical behaviors deemed to be problematic.
   a. Maintain an environment for open discussion
      i. Identify the problem to all parties
         a. maintain a focus on the problem
         b. use questions to gather and redirect discussion as needed
      ii. Be open to suggestions, alternatives, ideas, and compromise
      iii. Be succinct: know what you want to say and stick to the point
      iv. Use body, face, and voice to keep the environment non-threatening
      v. Use “cooling-off periods” as needed to keep all parties calm
      vi. PRACTICE
b. Manage defensiveness
   i. Prepare by being aware of sensitive areas
   ii. Prepare by separating the facts from your impressions
   iii. Prepare by considering your own role; how you may have contributed
   iv. Prepare by planning how to use a positive approach: (“building”) to work from the strengths of the individual
   v. Prepare by being sure that your message and limits are clear in your mind
   vi. Prepare by practicing/rehearsing
   vii. Focus on the behavior, not the person
   viii. Focus on the professional requirements that are not being met
   ix. Work to establish a goal (or goals) that is (are) mutually acceptable to all parties involved
   x. Be prepared to have a third party present if needed, especially in difficult discussions

c. Promote collegiality through disclosure and sharing
   i. Focus on the completion of the task
   ii. Complete the task by each person fulfilling his/her responsibilities within his/her role
   iii. Use collegiality to define roles, not to put each person on the same level
   iv. Work together as colleagues respecting each other’s roles to complete a task

d. Use disclosure to help each person understand each other person’s perception of roles and responsibilities
   i. Use effective confrontation and negotiation skills
   ii. Problem presentation
   iii. Problem resolution
   iv. Interpersonal dimension

e. Always pay attention to written communication while planning learning experiences and while communicating with students
   i. Formative Evaluation Instruments: Weekly Planning Form, Critical Incident Report, Anecdotal Record, Professional Behaviors
   ii. Student Program Planning Flow Chart (weekly/2 weeks/4 weeks) — See Section 3
   iii. Learning contracts
The attached detailed clinical objectives reflect the results of a discussion with [NAME], CCCE/Cl at [FACILITY], in which we clarified expectations of my behavior and/or performance, in areas that were identified as problems [WHEN?].

The purpose of defining specific performance statements is to clarify the expectations of my performance during the remainder of my clinical experience at [FACILITY].

I understand that I must incorporate these suggestions into my daily activities at [FACILITY]. Failure to successfully meet these objectives by [DATE] will result in [CONSEQUENCES: EG, FAILURE OF THE CLINICAL EXPERIENCE, EARLY TERMINATION OF THE EXPERIENCE].

I understand that emphasis on these objectives should in no way be construed to mean that the remainder of the goals and objectives for this experience are less important, or that successful completion of the remaining objectives is not required for successful completion of this experience.

__________________________   _________________
Student signature               Date

__________________________   _________________
CCCE/Cl signature               Date
# Form #1
**Negotiation/Confrontation Assessment Form**

**Directions:** CIs should rate themselves and be rated by the student using this form.

<table>
<thead>
<tr>
<th>PROBLEM PRESENTATION</th>
<th>Self</th>
<th>Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>States rationale for meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>States the problem clearly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illustrates the problem with specific examples</td>
<td></td>
<td></td>
</tr>
<tr>
<td>States why the performance presents a problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks accuracy of background information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requests other person’s point of view</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROBLEM RESOLUTION</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggests solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks feasibility of suggested solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Considers alternative solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicates limits of compromise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieves consensus on solution(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offers help to implement changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shares appropriate degree of responsibility in managing outcomes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERPERSONAL DIMENSIONS</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expresses feelings about the problem directly, using “I” messages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focuses on behavioral dimensions of the situation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balances compliments and constructive criticism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allows time for the other person to respond</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses appropriate attending skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintains appropriate body language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows mutual respect and positive regard</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\text{Modified from a document courtesy of Susan Deusinger, PT, PhD, FAPTA, Washington University, St Louis, MO.}\)
## Form #2
### Negotiation/Confrontation Assessment Form

**Directions:** Students should rate themselves and be rated by the CI using this form.

<table>
<thead>
<tr>
<th>PROBLEM PRESENTATION</th>
<th>Self</th>
<th>Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>States perception of rationale for meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>States perceived problem clearly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illustrates the problem with specific examples</td>
<td></td>
<td></td>
</tr>
<tr>
<td>States why the performance presents a problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks accuracy of background information</td>
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<tr>
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</thead>
<tbody>
<tr>
<td>Suggests solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks feasibility of suggested solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Considers alternative solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>States specific behaviors that will lead to altered performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieves consensus on solution(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agrees to try to implement changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shares responsibility in managing outcomes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERPERSONAL DIMENSIONS</th>
<th>Self</th>
<th>Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expresses feelings with “I” messages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focuses on professional performance elements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balances compliments and constructive criticism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allows time for the other person to respond</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses appropriate attending skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintains appropriate body language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows mutual respect and positive regard</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1Modified from a document courtesy of Susan Deusinger, PT, PhD, FAPTA, Washington University, St Louis, MO.
Final Activity

At this point in the program small-group activities allow participants to apply what they have learned.

Step 1: View the formative evaluation/feedback session between the clinical instructor and Fran, the student from Activity 5 in section 2.

Step 2: Form a pair. One person will role play the CI and the other will role play the student Fran.

Step 3: Each person will review the following:
  • Confidential information for the student or the clinical instructor
  • Negotiation/confrontation assessment forms

Step 4: Each person defines the problem(s) based on the video and their respective confidential information.

Step 5: Practice (role play) the weekly meeting in which the CI and student discuss the problems they identified and negotiate mutually acceptable behavioral objectives and learning experiences.

Step 6: Complete the Negotiation/Confrontation Assessment Form. The CI completes the column labeled “self” on the CI form and the student completes the column labeled “self” on the student form. Exchange forms and complete the partner column.

Step 7: When all pairs have completed this task, reconvene to discuss the respective student problems, the resolutions that were worked out, and the process of confrontation and negotiation.
THE CASE OF FRAN

FINAL ROLE PLAY FOR NEGOTIATION/CONFRONTATION
WITH THE EXCEPTIONAL STUDENT

(Role Play Script)

SCENE
An acute care setting. The CI approaches Fran while she is doing something (eg, documenting a patient note, gathering equipment for next patient), so it is a formative feedback session with time constraints. Fran is a little distracted with the activity she was doing when the CI started talking to her, and an interruption contributes to the student and CI not finishing the conversation in a satisfactory manner. The scene should capture catching Fran off-guard, which may contribute to her unchecked response.

CI: Hi Fran. How did your examination of Mr Elliott go this morning?
Fran: Fine. I instructed him in some breathing exercises for his COPD and discharged him.
CI: I couldn’t help but notice that your examination seemed a little rushed, especially when you were auscultating his lungs and assessing his breathing sounds.
Fran: Well, I’m trying to manage my time this morning so that right after lunch I can assist the PT on the pediatric floor with an examination.
CI: Will you see Mr Elliott this afternoon before he is discharged?
Fran: No, he seems to be doing fine managing his COPD.
CI: But how will you know if he is able to perform his breathing exercises correctly?
Fran: They are not difficult exercises, and he didn’t have any questions about them before I left the room.
CI: Proper breathing is very important for Mr Elliott’s condition, and so are education and encouragement to stop smoking. Did you include this in your instructions today?
Fran: No.
CI: Why not?
Fran: I figure he has had COPD for several years, so if he’s not stopped smoking by now, he’s not going to. I feel like I’m wasting my time trying to convince him to change something he’s done for 30 years. Anyway, I figure he’ll be back again with another episode of dyspnea and shortness of breath.
CI: Fran, it seems to me that you do not like to work with Mr Elliott.
Fran: Patients coughing up phlegm and smoking while they are still on oxygen is not what I call fun.
CI: This is an acute care rotation; you know we have a lot of patients with breathing problems who can benefit from physical therapy. I think it would be good for you to select and see more patients with COPD in your caseload.
Fran: I’ve seen 3 or 4 already. I only have a couple weeks left and would like to get as much exposure to working with pediatric patients since that’s where I want to specialize after graduation.
CI: I know, and I see that you are selecting as many pediatric patients as possible, but this is not a pediatrics experience. You are here to learn and gain skills in managing patients of different ages and conditions.
Fran: Well, I’m hoping that with this being my final internship, and since I am meeting my weekly goals, that I can gain as much experience treating pediatric patients in an effort to build my resume and start working in a pediatric hospital after graduation.

The conversation is interrupted by the CI getting paged/beeper goes off.

CI: This could be an emergency. I need to check on it right away. Fran, I feel we need to continue this discussion during our weekly meeting tomorrow.
Program Summary

At this point, you should be prepared to:

1. Develop a planned educational experience.
2. Establish objectives and learning experiences for the program.
3. Maintain an environment that is conducive to effective clinical learning.
4. Give feedback to the student during the process.
5. Evaluate student clinical performance in the cognitive, psychomotor, and affective domains.
6. Adapt each of these standard skills to manage a program for the exceptional student.
REFERENCES


SECTION VII

Answer Keys and Additional Recommended Resources
Page 36, Activity 1 (Find Someone Who…)

Page 40, Activity 2
1. Affective
2. Cognitive
3. Cognitive
4. Psychomotor
5. Cognitive, affective
6. Cognitive

Page 41, Activity 3A
1. Knowledge
2. She is unable to select the interventions that are most appropriate to the patient.
3. At the minimum level of evaluation or higher to include analysis or synthesis.
4. She seems to have “knowledge” that the interventions she is choosing are appropriate. Has she considered all the alternatives?

Page 42, Activity 3B
1. Attitude
2. Curt does not value the opinions of others and the team process as it relates to the care and management of his patients.
3. “Receiving”
4. a. Seek to determine whether Curt recognizes the impact of his communication skills on other team members and the team process.
   b. Have Curt develop an outline of team members and the value that each team member plays in a patient’s recovery.

Page 45, Activity 4
a. Following the lecture, know the steps in applying a below-knee prosthesis.
   1. Audience and criterion are missing.
   2. No. Cannot measure “know.”
   3. Following the lecture, the physical therapy student will <correctly> describe the steps in applying a below-knee prosthesis. <correctly = criterion>

b. Following a discussion with the CI, the student will study the preferred format for documenting initial examinations.
   1. As stated, the criterion is missing. Nothing indicates how well student must “study.”
   2. No. “Study the format” is process oriented rather than outcome oriented.
   3. Following a discussion with the CI, the student will document an initial examination using the preferred format.

c. Given all the necessary supplies, the student will correctly demonstrate and explain the proper taping for a “goalkeeper’s thumb” injury.
   1. Nothing is missing.
   2. No. Two outcomes are listed: demonstrate and explain.
   3. Make 2 objectives, 1 for each of the verbs. Given all the necessary supplies, the student will <correctly> demonstrate (or explain) the proper taping for a “goalkeeper’s thumb” injury.
d. **The instructor will show the student how to take blood pressure.**

1. As stated, the criterion is missing. Nothing indicates how well and under what circumstances the student will perform the skill of taking a blood pressure.
2. No. Instructor-centered rather than student-centered.
3. By the end of the week, the student will be able to accurately take a resting blood pressure on all patients.

**Page 46, Previous Activity 3A**

1. Lucy will correctly list all of the interventions appropriate for . . .
2. Lucy will explain the rationale for all interventions that she has identified.
3. Lucy will compare and contrast identified interventions vis-à-vis outcomes, cost effectiveness, and resources.

**Page 46, Previous Activity 3B (Curt)**

1. Following a team meeting, Curt will recognize the impact of his communication skills on other team members.
2. Curt will demonstrate value for team meetings by attending all meetings as scheduled.
3. Following each team meeting, Curt will list 1 example or valuable insight gained from another team member regarding 1 of his patients.

**Page 48, Activity 5**

1. Self-directed learner; problem-centered learner
2. Yes. Fran has not sought relevant concepts and is not ready to learn in this area. Fran does not appreciate the implications of respiratory function in a broad array of patient problems.
3. Review with Fran the relationships between pediatric diagnoses and pulmonary physical therapy (eg, cystic fibrosis, asthma, pediatric burns). Discuss pulmonary physical therapy as an entry-level competency.

**Page 49, Activity 6 (Learning Styles Inventory)**

**Page 52, Activity 7**

1. Notes are not completed on time. He does not use his free time well. He has not written learning objectives. Patients’ plans of care are not clearly defined and written. He does not participate in staff discussions on patient problem solving. A broader problem may be that Raj and Lorraine approach learning differently with different learning styles.
2. Consider strategies that allow Raj to use his predominant learning style (ie, discuss with Raj when it is appropriate to be “experimental” in his clinical learning experiences). Consider strategies that push Raj to use a less dominant learning style (ie, developing a series of alternative plans of care in advance identifying why they are indicated). Clarify for Raj responsibilities that are “nonnegotiable” regardless of learning style (ie, notes written in a timely fashion).

**Page 53, Activity 8**

1. a) Yes, criterion implied with “distinguish”
   b) Yes
c) and d) The student will distinguish between motor planning problems and weakness in a patient with hemiplegia.
e) Cognitive
2. a) No; difficult to demonstrate acceptance
   b) Yes
c) and d) By seeking out appropriate guidance from the CI, the student will identify areas of limited knowledge and experience.
e) Affective
3. a) No; no criterion
   b) Yes
   c) and d) The student will prepare a treatment room for an established program for a child with hyperactivity within 5 minutes.
   e) Psychomotor

4. a) Yes
   b) Yes
   c) and d) The student will list appropriate tests and measures for the full examination of a patient complaining of knee pain.
   e) Cognitive

5. a) No; no criterion. Condition “given a patient with a torn meniscus” is implied.
   b) No; describes 2 outcomes
   c) and d) The student will accurately describe the necessary tests and measures for identification of a torn meniscus. OR Given a list of tests and measures used to diagnose a torn meniscus, the student will correctly explain the purpose of each test and measure.
   e) Both are cognitive

6. a) Yes
   b) Yes
   c) and d) The student will correctly reproduce a neurodevelopmental treatment program after observing the intervention 2 times with the same patient.
   e) Psychomotor

7. a) No; no criterion; condition is implied
   b) No; too general; too vague
   c) and d) The student will demonstrate professional behavior by consistently speaking with tact and diplomacy.
   e) Affective

8. a) Yes; condition is implied
   b) No; describes 2 outcomes
   c) and d) The student will demonstrate the ability to objectively identify manipulative behavior. OR Given a patient with manipulative behavior, the student will successfully maintain an appropriate helping relationship.
   e) The first objective is cognitive. The second objective is affective.

9. a) Yes; condition is implied
   b) Yes
   c) and d) The student will demonstrate the ability to set appropriate priorities by completing assigned responsibilities on time.
   e) Affective

10. a) No; no criterion
    b) Yes
    c) and d) Based on evidence, the student will defend his/her choice of intervention(s) for a patient with low back pain to a level acceptable to the clinical instructor.
    e) Cognitive

11. a) No; no criterion
    b) No; process oriented as opposed to outcome oriented
    c) and d) The student will collect <6> articles on the effects of hydrotherapy. Condition is implied.
    e) Cognitive
12.a) No; no condition; no criterion  
b) No; not measurable except by virtue of some other observable behavior  
c) and d) In the clinical setting, the student will demonstrate motivation by asking  
to observe the interventions of other therapists.  
e) Affective  

13.a) Yes  
b) Yes  
c) and d) The student will design a plan of care for a child with cerebral palsy  
using an integrated program of therapeutic exercise techniques.  
e) Cognitive  

14.a) No; no criterion  
b) No; two outcomes  
c) and d) The student will <accurately> assess his/her performance following a treatment session  
by <critically analyzing his/her performance for completeness, effectiveness, and efficiency>.  
In this case, we opted to use the second part as the criterion for the first part rather than  
make 2 new objectives.  
e) Cognitive, affective  

15.a) Yes; condition is implied  
b) Yes  
c) The student will document the results of an initial examination thoroughly, concisely, and within 1 hour.  
d) Cognitive
Case 1: Donna
1. **Background information:**
   Based on academic and clinical experiences, is Donna able to: state the rationale for medical diagnostic testing and use of MRI, relate to previous experience with physician therapist interaction, and explain the patient’s medical background? What were her previous clinical education experiences? What evidence does Donna have to support her opinion? What have been Donna’s previous interactions with physicians? Is this patient’s physician receptive to requests from a physical therapist?

2. **Facility resources:**
   a. Interdisciplinary/team approach
   b. Opportunity to interact with physicians/other disciplines
   c. Physicians who are receptive to physical therapists’ requests for testing
   d. Experience/skilled clinical educator

3. **Behavioral goal:**
   Donna will provide a persuasive, clear, and concise consultation with the physician for the necessity of an MRI for this patient, by the end of this week. (Donna may be persuasive and correct, but the MD will not agree.)

Case 2: Juan
1. **Background information:**
   Based on academic and clinical experiences is Juan able to: demonstrate knowledge of safe patient handling techniques, perform proper body mechanics, use teaching skills, prepare (including completing required content) materials, provide appropriate pacing, and assess participants understanding of the information?

2. **Facility resources:**
   a. Appropriate space
   b. Outline of course content
   c. CI who is willing to share expertise

3. **Behavioral goal:**
   Juan will instruct the nurse’s aide body mechanics workshop, scheduled for 3 weeks from today, independently, addressing the required content and skills.

Case 3: Suzanne
1. **Background information:**
   Based on academic and clinical experiences is Suzanne able to: demonstrate knowledge of the role and responsibilities of a PTA, of adult learner characteristics, and of effective personal interactive skills?

2. **Facility resources:**
   a. Opportunity to practice patient care
   b. Opportunity to interact with other students in physical therapy
   c. Atmosphere receptive to students
   d. An experienced/skilled CI
   e. Valuable resources related to direct supervision, best practice, state laws and regulations, and Medicare requirements for supervision of support personnel

3. **Behavioral goal:**
   By the end of the next week, Suzanne will appropriately direct and supervise Dianna’s work with a patient assigned by the CI.
Page 74, Activity 5

a. Roger is having difficulty in the psychomotor and affective domains. He is in the “acquisition” level of learning, still requiring active CI input. He needs to take full advantage of practice opportunities and feedback provided. He needs to demonstrate adult learning behaviors (self-directedness, a readiness to learn, and the use of his past experiences in learning) to improve his targeted behavior and successfully reach his goal.

b. Student Program Planning Flow Chart

Student’s Name: Roger
Instructor’s Name: ________________
School: _________________
Date of Clinical Experience: Add date of conference, which experience, what week of experience

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific Targeted Behaviors</strong></td>
<td><strong>Long-term Goals</strong></td>
</tr>
</tbody>
</table>
| Patient handling for patients with CVA and abnormal movement patterns | By mid-evaluation, Roger will be able to correctly control patients with CVAs and abnormal movement patterns during intervention. | By the end of next week, Roger will be able to correctly adjust patient contact with 2 patients with CVA. | • Roger will observe a PT working with a patient with abnormal movement patterns, and then repeat the same handling techniques, with feedback from the PT. | • Patient population
• Expertise of clinical staff
• Opportunity for student to practice patient care
• Staff willing to share expertise |
Anecdotal Record (format from Shea et al)
The CI simply records the facts of “what happened,” offering no judgments mixed with facts.

---

**Anecdotal Record**

**Student:** Jane  
**Evaluator/Observer:** Robert

**Setting (place, people involved, atmosphere, etc):** Jane had made an appointment with Mrs J, who in the past week has refused physical therapy twice. When Jane arrived, the patient was on the telephone. Jane told the patient that she would return in a minute and asked the patient to end the conversation. When Jane returned, the patient was still on the phone and made no move to end the conversation.

**Student’s Action or Behavior:** Jane interrupted Mrs J and firmly, but politely, asked her to end the conversation, since she had agreed to have her treatment at this time.

**Evaluator’s Interpretation:** Jane demonstrated appropriate and assertive intervention to set limits on the patient’s behavior. Assertiveness has been a challenge for her, and this is a good example of an appropriate application of the skill.

**Student’s Comments:** It’s difficult for me to feel like I’m being rude, but I can see the importance of setting limits on the patient’s behavior.
The Critical Incident Report (format from Shea et al)

Directions: Record each entry clearly and concisely without reflecting any biases.

<table>
<thead>
<tr>
<th>Date (Time)</th>
<th>Antecedents</th>
<th>Behaviors</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/2 at 9:30 am</td>
<td>Bruce was assisting a 76-year-old patient with a total hip replacement during her first attempt at ambulation, non-weight bearing, with a walker.</td>
<td>Bruce was text messaging on his cell phone while assisting the patient during ambulation. Bruce was not paying attention to the patient. Bruce did not note level of pain evidenced by the patient’s incorrect gait pattern and distress.</td>
<td>If unsafe behavior such as this continues to occur, it will be written on his permanent evaluation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date (Time)</th>
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<th>Behaviors</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/15 at 2:00 pm</td>
<td>Bruce was assisting a patient in transferring from wheelchair to bed.</td>
<td>Bruce did not lock the wheelchair prior to assisting the patient to a standing position.</td>
<td>This behavior will be recorded on Bruce’s permanent evaluation. If behavior such as this continues, his midterm rating on ASafety@ will be lowered and the ACC/DCE will be contacted.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date (Time)</th>
<th>Antecedents</th>
<th>Behaviors</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/22 at 11:00 am</td>
<td>On the cardiopulmonary unit: documentation following treatment session.</td>
<td>Documentation poor due to lack of thorough chart review and patient interview.</td>
<td>ACCE/DCE will be called to address repeated issues of safety, lack of concern for patient welfare, and interpersonal skills.</td>
</tr>
</tbody>
</table>

Student’s Signature: Bruce Student
Evaluator’s Signature: Karen Evaluator
Section V

Page 110, Activity 1

1. Physical therapist students are not required to be in line-of-sight of the professional supervising therapist/assistant (Federal Register, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. Additionally all state and professional practice guidelines for student supervision must be followed. Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy.

The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:

- The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign, but it is not necessary because the Part B payment is for the clinician’s service, not for the student’s services.)

(RAI Version 3.0 Manual, October 2011)

All time that the student spends with patients should be documented. APTA recommends that the physical therapist co-sign the note of the physical therapist student and state the level of supervision that the PT determined was appropriate for the student and how/if the therapist was involved in the patient’s care. (Refer to Medicare Student Supervision Chart on page TK). Please see Supervision Under Medicare chart for clarification of students working with individual, group, and concurrent therapy.

2. Actually the term “billing” is a misnomer. In the SNF setting if the PT or PTA student provides the service while in line-of-sight of the PT or PTA CI, then Medicare Part A permits the minutes to count toward the Minimal Data Set (MDS). (Refer to Medicare Student Supervision Chart on page TK.)

3. Physical therapist assistant students are not required to be in line-of-sight of the professional supervising therapist/assistant (Federal Register, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. The minutes of student services count on the Minimum Data Set. Medicare no longer requires that the PT/PTA provide line-of-sight supervision of physical therapist assistant (PTA) student services. Rather, the supervising PT/PTA now has the authority to determine the appropriate level of supervision for the student, as appropriate within their state scope of practice. Additionally all state and professional practice guidelines for student supervision must be followed. Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy.

The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:

- The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign, but it is not necessary because the Part B payment is for the clinician’s service, not for the student’s services.)

(RAI Version 3.0 Manual, October 2011)

APTA recommends that the physical therapist and assistant should co-sign the note of physical therapist assistant student and state the level of appropriate supervision used. Also, the documentation should reflect the requirements as indicated for individual therapy, concurrent therapy, and group therapy the same as for the physical therapist student. (Refer to Medicare Student Supervision Chart on page TK). Please see Supervision Under Medicare chart for clarification of students working with individual, group, and concurrent therapy.

4. As with the PT student under line-of-sight of the PT supervisor, the minutes of PTA student services count on the MDS.
1. Only the services of the physical therapist can be billed and paid under Medicare Part B. The services performed by a physical therapist student are not reimbursed even if provided under “line of sight” supervision of the therapist; however, the presence of the student “in the room” does not make the service unbillable. For Medicare Part B, the licensed physical therapist with a student cannot be managing 2 patients at the same time, such as in an open gym, to meet the conditions provided below.

Therapists may bill and be paid for the provision of services in the following scenarios:

• The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.

• The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.

• The qualified practitioner is responsible for the services and, as such, signs all documentation. (A student may, of course, also sign, but it is not necessary since the Part B payment is for the clinician’s service, not for the student’s services).

APTA recommends that the licensed physical therapist complete documentation when supervising a physical therapist student. Documentation provided by students that is co-signed is a red flag for auditors with regard to whether or not the Medicare Part B regulations were followed.

2. Only the services of the physical therapist can be billed and paid under Medicare Part B. The services performed by a physical therapist student are not reimbursed even if provided under “line of sight” supervision of the therapist; however, the presence of the student “in the room” does not make the service unbillable. For Medicare Part B, the licensed physical therapist with a student cannot be managing 2 patients at the same time, such as in an open gym, to meet the conditions provided below.

Therapists may bill and be paid for the provision of services in the following scenarios:

• The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.

• The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.

• The qualified practitioner is responsible for the services and, as such, signs all documentation. (A student may, of course, also sign, but it is not necessary since the Part B payment is for the clinician’s service, not for the student’s services).

Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

APTA recommends that the licensed physical therapist complete documentation when supervising a physical therapist student. Documentation provided by students that is co-signed is a red flag for auditors with regard to whether or not the Medicare Part B regulations were followed.

In addition, Medicare supervision regulations with respect to PTAs in a comprehensive outpatient rehabilitation facility (CORF) state that the services must be furnished by qualified personnel. If the personnel do not meet the qualifications in 485.705, then the qualified staff must be on the premises and must instruct these personnel in appropriate patient care service, and techniques, and must retain responsibility for their activities. A qualified professional representing each service made available at the facility must be either on the premises of the facility or must be available through direct telecommunications for consultation and assistance during the facility’s operating hours.
In addition, however, APTA has a position, Procedural Interventions Performed Exclusively by Physical Therapists (HOD P06-00-30-36), with regard to the PTA that states that “direct personal supervision requires that the physical therapist, or where allowable by law, the physical therapist assistant, is physically present and immediately available to direct and supervise tasks that are related to patient/client management. The direction and supervision is continuous throughout the time these tasks are performed. Telecommunications does not meet the requirement of direct personal supervision.” Note that this position is less liberal than that of Medicare. In addition, care to be delivered must be within the state practice act and scope of the work of the PTA.

According to the APTA policy Ethical and Legal Considerations for Clinical Education (HOD P06-01-16-18), physical therapist and physical therapist assistant students are obligated to communicate information to their academic program regarding clinical education experiences that appear to be in conflict with these standards, policies, and positions. APTA has a policy, Financial Considerations in Practice (HOD P06-99-13-17) that opposes participation in underutilization or overutilization of services for personal or institutional gain, or participation in services that is in any way linked to the financial gain of the referral source.
ADDITIONAL RECOMMENDED READING


