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An Alternative Model for First Level Clinical Education Experiences in Physical Therapy

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Abstract
Purpose: To describe a self-contained model of clinical education that has been used for first level clinical experiences in the education of physical therapy (PT) students. Description of Model: A self-contained model of clinical education is defined as students completing supervised patient contact experiences with university faculty members serving as clinical instructors. University faculty directly supervised an average of 8 to 10 PT students in a collaborative format, in a variety of clinics, one day every other week. This took place during the fall and winter semesters, beginning the first month of the program and continuing until the full-time clinical education component, in the spring of the second year. The student groups at each facility were comprised of first and second year students that worked collaboratively in pairs. Results: The collaborative, self-contained model was an efficient way to administer first level clinical education experiences by combining internal and community resources. Conclusion / Possible Recommendations: This model increased availability of clinical education sites for first level PT students. The model facilitated clinical placement into community organizations without physical therapy services, and enhanced the provision of services in facilities with otherwise limited resources. A self-contained model can work for other health profession programs that are challenged with clinical placements. It can also work if a program wants improved integration of didactic and clinical skill objectives and is structured to facilitate this model.

Introduction

Physical therapist clinical education in the 1:1 student /clinical instructor (CI) model, in which the CI is employed by the facility, has been used for decades in spite of the fact that healthcare delivery in the United States has been in a state of constant evolution.[1] Clinical structure and financing of healthcare have resulted in systemic and institutional changes, including decreased Medicare and private insurance funding for physical therapy services that have resulted in changes in physical therapy staffing patterns. This decreased funding for services resulted in increased productivity demands per therapist. The result was the need for fewer therapists per clinic in some situations. Physical therapist academic institutions and clinical facilities have been slow in shifting clinical education paradigms to be consistent with these healthcare environmental changes. This has resulted in clinicians being less willing to accept first level (prior to full-time internships) students that require a greater time commitment (secondary to less didactic instruction and less lab skill mastery) than students in final, full-time rotations. Therefore, placements for first level students have presented unique challenges in the current healthcare environment because clinical sites are less willing to offer clinical internships for first level students. The university was, and will continue to be, forced to develop alternative models to provide students with the exposure to clinical experience needed at this early point in the curriculum.

In November 1998, the American Physical Therapy Association convened a consensus conference on clinical education. The purpose was to explore innovative clinical education models for physical therapist professional education.[2] One of the models presented was the self-contained model, in which university faculty act as clinical instructors, supervising students during patient contact experiences.[2] This model was developed to provide greater continuity between didactic and clinical components of the physical therapist curriculae.[2] The academic institution has increased control over the quality of the clinical components of the curriculum using

university faculty who are licensed to practice physical therapy within the jurisdiction. Partnering relationships are developed that afford the academic institution the opportunity to provide services within various healthcare facilities. Facilities can include public and private institutions with and without established physical therapy services (e.g. community agencies), with services provided through contractual or pro bono arrangements. Contracts are established that define the supervision and evaluation of the student(s), liability of the involved parties, and the accreditation and credentialing of faculty. Faculty roles and workload at the academic institution are redefined to include the role as faculty clinical instructor.

Medicine, nursing, optometry, and dentistry programs have been engaged in the utilization of self-contained preceptorship clinical education models for many years.[3-6] The formats of these learning experiences include integration across the curriculum, integration into existing courses, and separate required and elective courses.[6-14] Reported outcomes of these experiences showed that students reported positive learning experiences, increased ethnic consciousness and cultural competence, and developed communication and problem-solving skills.[7-14] Although the self-contained model has been used in other health professions[3-6], there was no information published on the use of the model in physical therapy prior to the 1998 American Physical Therapy Association Consensus Conference. To date, no published studies were identified that looked at the use of the self-contained model in physical therapist clinical education. The purpose of this article is to describe a self-contained model of clinical education that has been used for first level clinical experiences in the education of physical therapy students.

A Model for First Level Clinical Education Experiences

A self-contained clinical education model was proposed by Stern and Rone-Adams to the entire Nova Southeastern University (NSU) physical therapy faculty in the summer of 1998 based on recognition of the need to change the clinical education paradigm. This was coincidental with the American Physical Therapy Association Consensus Conference recommendations that this model could be a viable option for clinical education in physical therapist education. The model was developed following notification of contract cancellations for first level internships in skilled nursing facilities (SNFs) as a consequence of the implementation of the Balanced Budget Act (BBA) of 1997.[15-17] The BBA phased in a prospective payment system for care received in a skilled nursing facility that paid a per diem rates for covered services, including physical therapy.[15] The change to this system of reimbursement decreased the funding available to SNFs for physical therapy services and increased the productivity demand. Contract cancellations were the result of the conflict between productivity demands imposed on practicing physical therapists and the time demands of supervising first level students.

A pilot program for a self-contained clinical education program for first level students was designed and presented to the physical therapy faculty in the fall of 1998. Following faculty approval, potential clinical sites were identified by the clinical education team. The sites were selected to give the students exposure to a variety of venues, patient diagnoses, and acuity levels. It was initially challenging to establish support from community facilities and organizations as this model was unique in physical therapy education in 1998-99. Community support for the pilot study was offered through a local corporation with multiple skilled nursing facilities and creative-minded physical therapy managers. The managers saw this as an opportunity to expand services to those that otherwise may not have been entitled to services as a result of changes in reimbursement and staffing patterns. In order to expand the program in fall of 1999 to all students, additional community organizations that did not offer physical therapy services were approached and agreed to participate based on the success of the pilot program. Since 1999, the physical therapy program has been approached by multiple community organizations inviting provision of services at their sites. Although resources precluded expansion, it established the presence of community support and need, and the value of the program to the community.

Individual contacts were made with sites that agreed to participate. Contracts were established by the university attorney and signed by all appropriate parties. Faculty CIs had to comply with requirements of facility licensure and staff requirements. Professional liability insurance for faculty and students was already included in the university's professional liability coverage, so no further liability insurance was needed. The pilot program was completed during the spring of 1999, and implemented for all students in the fall of 1999 based on the success of the pilot program. Success was determined based on individual interview feedback from the physical therapy staff at each site used for the pilot, student feedback during CI/student conferences, and faculty CI confirmation that students had met the course objectives. Success was also confirmed at the start of full-time internship by readiness for practice determined by community clinical instructors.

The sites used at the inception of the program, consisted of two skilled nursing facilities, an adult day care center, a residential homeless assistance center, a university-managed outpatient clinic, and a pediatric inpatient and outpatient facility. Neither the homeless assistance center nor the adult day care center had established physical therapy services. All services provided during this portion of the program were pro bono and were provided to patients and clients who were considered underserved. Students rotated to three different facilities,

with different faculty clinical instructors during three semesters.

Six university faculty were assigned to settings in which they had knowledge and prior clinical experience. All faculty were certified as clinical instructors by the Florida Consortium of Clinical Educators (FCCE). The FCCE is a group of Florida academic and clinical physical therapists whose mission is to develop and support quality physical therapist clinical education.[18] The FCCE offers a course to certify physical therapist clinical instructors in the state of Florida. FCCE certification of clinical instructors is on a voluntary basis. Certification of the faculty clinical instructors in this model was used to provide baseline training in the common tools used in the clinical education of physical therapist students.

The physical therapy program was a two year program in which students completed their final clinical internships during the spring of the second year. As originally designed, the self-contained clinical education program began in the second month of the curriculum. Students and faculty were in the clinics one day every other week during the fall and winter for a total of three semesters. This continued until the start of the full-time clinical education component which began in the spring of the second year. University faculty directly supervised an average of 8 - 10 physical therapy students in a collaborative format (1: 8 - 10). The student groups at each facility were comprised of first and second year students that worked collaboratively in pairs, with second year students mentoring first year students.

The primary learning objectives for the first year students included evaluation, examination, assessment skills, and development of professional behaviors as defined by the Generic Abilities behaviors.[19] The Generic Abilities is a skill set developed to identify critical professional behavior skills designed for student self assessment in the physical therapy curriculum. Learning objectives for second year students included cognitive, psychomotor, and affective skills practiced the first year of the program. Emphasis for the second half of the program included the addition of the development of intervention plans and determination of prognosis as appropriate to the client/patient population based on didactic curriculum components. Skills practiced by the students during the clinical internship were the skills the students had learned and practiced in the didactic labs on campus. (See Appendix A for a sample of objectives for first year students and Appendix B for second year students).

A typical day consisted of morning rounds with all students, followed by paired student group client interactions, and ending with afternoon discussion and wrap up with all students. In facilities with physical therapy services, clients were identified by facility PT staff. All clients consented to work with the students. In facilities without physical therapy services, clients self selected to receive services. Special activities were interspersed throughout the assigned time and included client and staff in-services, adapted recreational activities, assisting with feeding programs, and presentations by students and other health professionals.

In addition to ongoing feedback from the faculty CI during each of the three rotations, students completed the Generic Abilities as a self-assessment at the end of each of the three clinical rotations.[19-20] Students then met with faculty clinical instructors, discussed the self-assessment, and received feedback. Additionally, each student completed a reflective journal that was discussed with the faculty clinical instructor at the end of each rotation. [21] The purpose of the reflective journal was to facilitate learning by allowing the students to think about specific experiences in the clinic, consider alternative ways of dealing with the experience and reflect about it. Students writing about what they did and what they learned assisted students in becoming more thoughtful, reflective, and analytic.[21] The format used for the reflective journal was the format suggested by Schon and can be seen in Appendix C.[21]

Discussion

Implementation of self contained model presented both benefits and challenges to the faculty, students and physical therapy program. Benefits included the following:

- control over the quality of the learning experiences including student-learning objectives
- scheduling of experiences to complement the academic content and class scheduling
- early identification of students with weaknesses in clinical skills and academic knowledge
- bridging of the gap between the clinical and academic settings
- faculty clinical practice in areas of experience and comfort
- fulfillment of the mission of the university, the academic program and the American Physical Therapy Association for pro bono services to the community and the underserved

There were various challenges encountered in implementing this type of model. First, establishment of one consistent clinical day throughout the curriculum was difficult due to the various commitments of faculty, availability of rooms on campus for classes on alternate days, and the overall university schedule. Secondly, the availability of makeup days for student absences was limited. Alternate arrangements had to be made for students to make up missed days in the university managed clinic. This placed an additional burden on the staff in the university clinic. Thirdly, coverage for faculty clinical instructor vacation time and unplanned absences was a challenge as there had to be release time from other responsibilities. Lastly, there were some inconsistencies of learning experiences across different

types of facilities, as different types of patients presented the opportunity to practice different types of skills.

Over time, in the seven years since the inception of the program, these challenges have been effectively managed in the following ways. Tuesday has been established as the permanent clinic day and no other classes are scheduled on Tuesdays. The same five faculty members serve as the clinical instructors rotating fall and winter semesters as part of their regular academic responsibilities. The integration of the clinical instructor responsibilities into the academic responsibilities and redistribution of responsibilities to other faculty members has resulted in essentially no cost to the academic institution. Responsibilities taken from the faculty serving as clinical instructors was minimal as the time commitment was one day a week and these responsibilities were easily picked up by faculty members not serving as clinical instructors. An additional faculty member is available in the case of faculty absence. The sites have been modified so that all students go to the same type of facility as other students during the semester. This includes one semester of inpatient experiences in SNFs, and one semester of outpatient experiences in a homeless center and the university-operated clinic. This allowed consistent objectives to be set for all students during the semester and increased assurance that students would be able to reach the stated objectives. Additionally, first and second year students were separated to ensure achievement of skills sets consistent with coursework. Although students are in clinic every other week, faculty CIs are assigned to the same clinic for a full semester, every week, with two different groups of alternating students. Therefore, student absences can be managed the week following the absence. In order to more objectively assess outcomes, the Generic Abilities form has been replaced by a self- designed Clinical Assessment Form (CAF) that specifically reflects the objectives and skills for the specific semester, including professional behaviors and clinical skills. It was felt that the Generic Abilities did not adequately assess hands on clinical skills learned during the semester. Therefore the CAF was developed to incorporated both professional behavior skills and clinical skills. (See Appendix D for a sample of the CAF.)

The behaviors identified for the CAF were determined based on didactic course objectives, the Generic Abilities, the American Physical Therapy Association's Clinical Performance Instrument, and ranking of behaviors by university faculty. Students self assess at midterm based on the course objectives, and complete a final self assessment on the CAF, which is then compared to the faculty CI's CAF for consistency. Students also complete reflective journals as mentioned earlier.[21]

Summary

Establishment of a collaborative community based first level clinical education program has implications for the training of health professionals.[22-23] The self-contained model is one way to administer first level clinical education experiences by combining internal and community resources. It also relieves the clinical sites from the burden of supervising the first level students. This model increased the availability of clinical education sites for first years students by facilitating expansion into communities and facilities that otherwise are unable to provide placements secondary to limited resources. Additionally, the program provided the opportunity for students to work in facilities where access to physical therapy services was otherwise limited because of reimbursement issues (e.g. Medicare, Medicaid). If a physical therapist or physical therapist assistant program or any other health profession program is challenged with clinical placements and is structured to facilitate this model (e.g. appropriate liability coverage, teaching load), it can be a model for early exposure of students to patient care experiences.

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APPENDIX A: OBJECTIVES FOR FIRST YEAR STUDENTS:

COURSE OUTCOMES:

Upon completion of this course, students will have the clinical knowledge and skills to effectively: communicate with clients/patients and others in written and oral format, demonstrate appropriate therapeutic presence, demonstrate appropriate body mechanics, perform client/patient histories, medical record review and basic psychomotor clinical skills as indicated in the learner objectives of Clinical Skills I and as appropriate, Clinical Skills II. Students will also understand the reimbursement processes in skilled nursing facilities, both short term skilled and long term.

Students will gain the critical thinking skills to facilitate application of the knowledge gained in this course to effectively and safely handle patients with impairments and functional limitations presented by the clients encountered in TIER IA.

OBJECTIVES:

Cognitive: Upon completion of this clinical placement, students will be able to:

1. Identify the components and types of client/medical records at the assigned facility.
2. Interpret and integrate the relevant information from the medical record in decisions regarding basic skills.
3. Perform client/patient histories as determined by the medical record or client interview.
4. Recognize general precautions, relative contraindications and contraindications from the medical record as they relate to the performance of general clinical skills.
5. Apply general reimbursement concepts and identify the relationship between current procedural terminology (CPT) coding and International Classification of Disease (ICD-9) coding for the clients served.
6. Identify standard manual wheelchair components and general parameters and considerations for recommendations for short-term wheelchair use and transportation.
7. Analyze and describe gait patterns demonstrated by clients using standard terminology.
8. Compare and contrast assistive gait devices and their appropriate applications: walkers, rollators, straight canes, quad canes, hemi walkers, crutches, forearm crutches.
9. Determine appropriate gait patterns and devices.
10. Determine the relevance of examination findings to the skills appropriate in this course.
11. Understand what service learning is and articulate the benefits of it in physical therapy education
12. Determine appropriate landmarks for postural analysis.
13. Understand, analyze and apply positioning principles to maximize client/patient function and minimize complications.
14. Understand and analyze transfer/transitional movement skills, relative to client/patient presentation.

15. Understand and analyze bed mobility skills (as applicable by facility only), relative to client/patient presentation.
16. Understand the concepts of range of motion assessment
17. Understand the concepts gross strength assessment
18. Identify surface anatomical structures relevant to the assessment process.
19. Demonstrate appropriate therapeutic presence and verbal communication including: boundaries between professional and unprofessional interactions, and differentiation between empathy and sympathy.
20. Identify the type of facility assigned to and how clients are admitted and served by the facility.
21. Understand, articulate and demonstrate compliance with facility policies and procedures, including accreditation and licensing regulations.
22. Understand the role of the skilled nursing facility (SNF) in the health care continuum
23. Understand the levels of care and reimbursement in the SNF setting; long term care, skilled (RUGS), restorative, Medicare, managed care, Medicaid, other
24. Integrate service learning principles into the SNF experience and understand the relationship between curricular objectives and community partner (SNF) objectives

Affective: Upon completion of this clinical placement, students will be able to:

1. Synthesize and apply the effects of verbal communication with clients/patients and others.
2. Synthesize and apply the importance of non-verbal communication based on body language congruent with intended message for communication, recognize, interpret, and respond to the body language of others including eye and head movements, limb position, posture and gait, recognize the positive and negative effects one's touch may have on a patient's/client's emotions and behaviors.
3. Synthesize the impact of temporary and permanent disability.
4. Determine and analyze the impact of written communication in the medical record.
5. Integrate the concerns of the community partners in Service Learning
6. Reflect on the Service Learning aspects of the clinical experience

Psychomotor: Upon completion of this clinical placement, students will be able to, in a safe, effective, efficient manner, integrating appropriate body mechanics (in skills indicated) apply/demonstrate in the clinical context under direct faculty supervision:

1. Accurately performs a client/patient history using open and close ended questions of all systems, including documentation of findings
2. Accurately performs vital signs and document findings
3. Perform general screening, tests and measures including sensory: vital signs, light touch/pain, proprioception, vision, hearing, integument, general function, posture and reflexes and document findings
4. Perform medical record review extracting all relevant information
5. Document findings and actions for all procedures constructing complete, analytically sound, timely and legible documentation, presented in a logical format, using nonjudgmental, person-

first language, using proper syntax and grammatical rules with acceptable terminology and abbreviations, and incorporating CPT and ICD 9 coding

6. Manage standard manual wheelchairs with description of wheelchair components as applicable
7. Assess gait demonstrating safe gait guarding techniques, including standard weight bearing and other weight bearing patterns (as appropriate based on clients encountered) including documentation of assessment, intervention, goals/outcomes and other information as indicate
8. Assess bed mobility with documentation of assessment and other information as indicated
9. Assess basic positioning with documentation of assessment and other information as indicated (as applicable based on facility)
10. Perform transfers/transitional movements assessment with appropriate documentation
11. Perform general strength assessment/examination
12. Perform general range of motion assessment
13. Drape clients/patients appropriately to protect patient dignity and modesty
14. Palpate body landmarks with accuracy
15. Demonstrate appropriate therapeutic presence
16. Demonstrate appropriate verbal communication including clear articulation of instructions, non-verbal communication including gestures, tactile, skills, active/effective listening, empathetic responding and communication with those with impaired communication ability
17. Communicate effectively with facility staff
18. Demonstrate professional and ethical behaviors

APPENDIX B: OBJECTIVES FOR SECOND YEAR STUDENT

COURSE OUTCOMES:

Upon completion of this course, students will demonstrate clinical knowledge and skill to effectively: communicate with clients/patients and others in written and oral formats; appropriate therapeutic presence during interactions with patients/clients, families and facility staff of all ages and differing cultures; appropriate and safe body mechanics; ability to perform client/patient histories and interview and cognitive, affective and psychomotor clinical skills as indicated in the learner objectives of Clinical Skills I and II, Musculoskeletal I, Physical Agents, concurrent content from Musculoskeletal II, and other courses throughout the curriculum.

Students will also understand applicable reimbursement processes applicable to outpatients. Students will practice critical thinking skills to facilitate application of knowledge gained in the didactic curriculum to effectively and safely handle patients/clients encountered in Tier IB who have impairments and functional limitations.

OBJECTIVES:

Cognitive: Upon completion of this clinical placement, students will be able to:

1. Interpret and integrate relevant information from the medical record if available, or through patient client history and interview, in decisions regarding basic skills (i.e. screening, assessment, examination, evaluation, intervention).
2. Identify information needed for completion of client/patient histories and interviews as determined by the appropriate sources.
3. Recognize general precautions, relative contraindications and contraindications from the medical history as they relate to the performance of general clinical skills.
4. Apply general reimbursement concepts and identify the relationship between current procedural terminology (CPT) coding and International Classification of Disease (ICD-9) coding for the clients served.
5. Analyze and describe gait patterns demonstrated by clients using standard terminology.
6. Determine the relevance of examination findings to the selection of interventions appropriate as applicable
   to skills in this course.
7. Understand what service learning is and articulate the benefits of it in physical therapy education.
8. Understand the concepts of observational and goniometric range of motion assessment.
9. Understand the concepts of muscle performance and strength assessment .
10. Identify surface anatomical structures relevant to the skills presented in this course.

11. Demonstrate appropriate therapeutic presence, verbal and nonverbal communication including: boundaries between professional and unprofessional interactions, and differentiation between empathy and sympathy.
12. Identify the type of facility assigned to and how patients/clients are admitted and served by the facility.
13. Understand, articulate and demonstrate compliance with state, facility and university regulations, policies and procedures, including those of accreditation and licensing agencies v. regulations.
14. Integrate service learning principles into the outpatient experience and understand the relationship between curricular objectives and community partner objectives; BPH and NSU Clinic.
15. Develop intervention/treatment plans appropriate to initial examination findings and realistic goals for musculoskeletal disorders in patients with and without behavioral disorders, and other types of disorders encountered.
16. Identify opportunities for supervision and delegation of PT services (theoretical).
17. Determine when a referral is indicated for particular a patient/client.
18. Understand the role of pharmaceuticals in medical management and the implications for the rehabilitation team.
19. Understand the role of the PT as a consultant

Affective: Upon completion of this clinical placement, students will be able to:

1. Understand the effects of verbal communication with clients/patients and others.
2. Understand the importance of non-verbal communication based on body language congruent with intended message for communication; recognize, interpret, and respond professionally to the body language of others including eye and head movements, limb position, posture and gait; recognize the positive and negative effects one's touch may have on a patient's/client's emotions and behaviors.
3. Understand the impact of temporary and permanent disability.
4. Understand the impact of written communication in the medical record.
5. Understand the concerns of the community partners in Service Learning.
6. Reflect on the Service Learning aspects of the clinical experience.
7. Understand and reflect on how cultural differences and sexuality issues impact delivery of physical therapy.
8. Explore feelings about temporary and permanent disability, including mental illness.

Psychomotor: Upon completion of this clinical placement, students will be able to, in a safe, effective, efficient manner integrate appropriate body mechanics (in skills indicated) and apply/demonstrate in the clinical context under direct faculty supervision:

1. Accurately perform and document a client/patient history and interview using open and close-ended questions concerning all systems, including musculoskeletal.
2. Accurately perform vital signs and document findings.

3. Perform and document tests and measures including: vital signs; sensory (light touch, proprioception); vision; hearing; posture, goniometric ROM of the spine and extremities, muscle performance and strength of the trunk, neck and extremities, gait, pain, soft tissue integrity
4. Document findings and actions for all procedures constructing complete, analytically sound, timely and legible documentation, presented in a logical format, using nonjudgmental, person-first language, using proper syntax and grammatical rules with acceptable terminology and abbreviations, and incorporating CPT and ICD 9 coding.
5. Perform safe guarding techniques during all patient/client interaction.
6. Perform transfers/transitional movement assessment and training with appropriate documentation.
7. Perform and document therapeutic exercise intervention including stretching, strengthening and range of motion.
8. Perform and document physical agents such as hot packs, cold packs, ultrasound, electrical stimulation.
9. Appropriately drape clients/patients to protect patient dignity and modesty.
10. Accurately palpate body landmarks and for skin lesions/scars, extremity swelling, inflammation or infection, intra and extra articular conditions.
11. Compare end-feels: connective tissue stretch (firm and soft), connective tissue compression, bony, and springy.
12. Demonstrate appropriate therapeutic presence and cultural sensitivity.
13. Demonstrate appropriate verbal communication including clear articulation of instructions and of appropriate non-verbal communication including gestures, tactile, skills, active/effective listening, empathetic responding and communication with those with impaired communication ability.
14. Effectively communication with facility staff, student peers, patients/clients and clinical instructor
15. Demonstrate professional, legal and ethical behaviors including adherence to HIPAA regulations.
16. Perform myotome, dermatome, DTR, and primitive reflex testing.
17. Perform movement testing to assess for reactive vs. non-reactive musculoskeletal conditions.
18. Perform neural tension tests for upper and lower extremities.
19. Perform basic manual therapy techniques for spine and extremities.
20. Demonstrate strategic communication skills designed to improve the treatment of musculoskeletal disorders in patients with and without psychiatric and behavioral disorders.
21. Demonstrate appropriate patient/client education.

APPENDIX C:

REFLECTIVE JOURNAL FORMAT BASED ON SCHON'S MODEL

Nova Southeastern University
Entry Level Physical Therapy Program

Reflective Journal Format for Clinical Education

Based on Schon's Model

Student Name: _____ Date: _____
Type of facility: _____
Faculty CI or facility CI: _____

Knowing in Action:

Recognize Surprise:

Reflection in action:

Experiment:

Reflection on action:

APPENDIX D: CLINICAL ASSESSMENT FORM

NOVA SOUTHEASTERN UNIVERSITY
PHYSICAL THERAPY PROGRAM
CLINICAL ASSESSMENT FORM (CAF) TIER I (2006)

Student Name: _____

CI Name: _____

Facility: _____

Date: _____

INSTRUCTIONS:

For each behavior, please place a check on the appropriate line between the two anchoring behaviors to indicate where the student performs. Please add any additional comments to clarify your choice in the space provided as indicated.

Score:

Section 1 SAFETY
Section total: _____/

Section 2 PROFESSIONAL BEHAVIOR
Section total: _____/

Section 3 COMMUNICATION
Section Total: _____/

Section 4 PERFORMS A PHYSICAL THERAPY EXAMINATION
Section total: _____/

Section 5 DOCUMENTATION AND DESIGN OF PLAN OF CARE (year 2)
Section total: _____/

Section 6 PT TREATMENT NOTES (year 2)
Section total: _____/

Section 7 PERFORMS PHYSICAL THERAPY INTERVENTIONS (year 2)
Section total: _____/

Total: _____/

SAFETY:
Note: Failure to observe safety constitutes automatic failure of TIER I based on criteria below

1. Observes and appropriately complies with laws, rules, regulations, policies & procedures of facility:

	0	1	2	3	4	5	6	
Does not comply	__	__	__	__	__	__	__	Complies

2. Observes and appropriately complies with rules, regulations, policies & procedures of NSU:

	0	1	2	3	4	5	6	
Does not comply	__	__	__	__	__	__	__	Complies

3. Patient privacy: complies with HIPAA

	0	1	2	3	4	5	6	
Doesn't maintain	__	__	__	__	__	__	__	Maintains

4. Monitors vital signs throughout sessions as indicated by patient's medical history

	0	1	2	3	4	5	6	
Unsafe	__	__	__	__	__	__	__	Safe practice

5. Safety awareness

	0	1	2	3	4	5	6	
Unsafe	__	__	__	__	__	__	__	Safe practice

Harm to patient: Automatic failure at any time in TIER I
Error in first 2 TIER I days, without harm to patient will result in 4/6 total
Error on 3rd day will result in 3/6 total
Error on days 4 – 7 will result in failure and require remediation

COMMENTS:

PROFESSIONAL BEHAVIOR

1. Demonstrates confidence in patient/client interactions
   Nervous __ __ __ __ __ __ Confident

2. Demonstrates with patients
   No empathy __ __ __ __ __ __ Empathy

3. Demonstrates with patients
   Disrespect __ __ __ __ __ __ Respect

4. Demonstrates cultural competence
   Discriminates __ __ __ __ __ __ Sensitivity

5. Accepts feedback from staff
   Defensive __ __ __ __ __ __ Not defensive

6. Accepts feedback from CI
   Defensive __ __ __ __ __ __ Not defensive

7. Demonstrates initiative: Commitment to learning
   No __ __ __ __ __ __ Yes

8. Adjusts behavior
   Rigid __ __ __ __ __ __ Flexible

9. Makes appropriate observations, appropriately analyzes and does not discredit or criticize staff or facility
   Inappropriate __ __ __ __ __ __ Flexible

Section total: _____items x _____ = _____

Comments:

COMMUNICATION

1. Verbal behavior

With patients:	Inappropriate	__	__	__	__	__	__	Appropriate	
With others:	Inappropriate	__	__	__	__	__	__	Appropriate	N/A

2. Non verbal communication

With patients:	Inappropriate	__	__	__	__	__	__	Appropriate	
With others:	Inappropriate	__	__	__	__	__	__	Appropriate	N/A

3. Active Listening

With patients:	Ignores	__	__	__	__	__	__	Listening	
With others:	Inappropriate	__	__	__	__	__	__	Appropriate	N/A

4. Eye contact

With patients:	Inappropriate	__	__	__	__	__	__	Appropriate	
With others:	Inappropriate	__	__	__	__	__	__	Appropriate	N/A

5. Voice quality

With patients:	Inappropriate	__	__	__	__	__	__	Appropriate	
With others:	Inappropriate	__	__	__	__	__	__	Appropriate	N/A

6. Technical language

With patients:	Inappropriate	__	__	__	__	__	__	Appropriate	
With others:	Inappropriate	__	__	__	__	__	__	Appropriate	N/A

7. Patient's personal needs

	Ignores	__	__	__	__	__	__	Responsive

8. Interaction with patients

	Discourages	__	__	__	__	__	__	Encourages

Section total: _____items x _____ = _____

Comments:

PERFORMS A PHYSICAL THERAPY EXAMINATION: Initial examination, re-examination, screens

1. Examination Selection

	Inappropriate	__	__	__	__	__	__	Appropriate	

Examination Performance

	Inappropriate	__	__	__	__	__	__	Appropriate	
2. Vision									
	Inaccurate	__	__	__	__	__	__	Accurate	
3. Hearing									
	Inaccurate	__	__	__	__	__	__	Accurate	
4. Vital Signs									
	Inaccurate	__	__	__	__	__	__	Accurate	
5. Cognition & Communication									
	Inaccurate	__	__	__	__	__	__	Accurate	
6. Sensory									
	Inaccurate	__	__	__	__	__	__	Accurate	
7. Integument									
	Inaccurate	__	__	__	__	__	__	Accurate	
8. Gait									
	Inaccurate	__	__	__	__	__	__	Accurate	
9. Gait with assistive devices									
	Inaccurate	__	__	__	__	__	__	Accurate	
10. Transfers surface to surface									
	Inaccurate	__	__	__	__	__	__	Accurate	N/A
11. Transitional movement: sit < > stand									
	Inaccurate	__	__	__	__	__	__	Accurate	
12. Bed mobility									
	Inaccurate	__	__	__	__	__	__	Accurate	N/A
13. Gross strength									
	Inaccurate	__	__	__	__	__	__	Accurate	
14. Gross Range of Motion									
	Inaccurate	__	__	__	__	__	__	Accurate	
15. Gross balance									
	Inaccurate	__	__	__	__	__	__	Accurate	
16. Wheelchair management									
	Inaccurate	__	__	__	__	__	__	Accurate	
17. Overall Endurance									
	Inaccurate	__	__	__	__	__	__	Accurate	
18. Examination adjustments									
	Inappropriate	__	__	__	__	__	__	Appropriate	
19. Minimizes risk to self (body mechanics)									
	Unsafe	__	__	__	__	__	__	Safe	
20. Length of examination session									
(long or short) Inappropriate		__	__	__	__	__	__	Appropriate	

Section total: _____items x _____ = _____

Comments:

DOCUMENTATION OF PLAN OF CARE
Based on history and interview or medical record as applicable:

1. Demographic information

Incomplete __ __ __ __ __ __ Complete

2. Psychosocial information
Incomplete __ __ __ __ __ __ Complete

3. Environmental information
Incomplete __ __ __ __ __ __ Complete

4. Prior level of function
Incomplete __ __ __ __ __ __ Complete

5. Medical (primary) diagnosis(es)
Incomplete __ __ __ __ __ __ Complete

6. Physical therapy diagnosis(es)
Inappropriate __ __ __ __ __ __ Appropriate

7. Medical history

Incomplete __ __ __ __ __ __ Complete

8. PT Problem List/problem identification/summary

Incomplete __ __ __ __ __ __ Complete

9. Precautions
Incomplete __ __ __ __ __ __ Complete

10. Contraindications
Incomplete __ __ __ __ __ __ Complete

11. Patient/PT goals
PT established __ __ __ __ __ __ PT/patient Established

12. Time frames for goals
Inappropriate __ __ __ __ __ __ Appropriate

13. Therapeutic interventions (selects appropriately to match problems and goals)
Inappropriate __ __ __ __ __ __ Appropriate N/A
Incomplete __ __ __ __ __ __ Complete N/A

14. Frequency of treatment
Inappropriate __ __ __ __ __ __ Appropriate N/A

15. Duration of treatment
Inappropriate __ __ __ __ __ __ Appropriate N/A

16. Documentation on facility forms
Inaccurate __ __ __ __ __ __ Accurate

17. Signature(s) on documentation
Inappropriate __ __ __ __ __ __ Appropriate

18. CPT codeable verbiage
Inaccurate __ __ __ __ __ __ Accurate

19. Rehabilitation potential
Inaccurate __ __ __ __ __ __ Accurate

20. Assessment of body systems (as appropriate)
Incomplete __ __ __ __ __ __ Complete N/A

21. Discharge Plan
Inappropriate __ __ __ __ __ __ Appropriate

Section total: _____items x _____ = _____

Comments:

PT TREATMENT NOTES (Documentation)(year 2)

1. Signature(s) on documentation									
	Inappropriate	__	__	__	__	__	__	Appropriate	
2. Entries dated									
	None	__	__	__	__	__	__	All	
3. Body areas treated									
	Not included	__	__	__	__	__	__	Included	
4. CPT codeable verbiage									
	Inaccurate	__	__	__	__	__	__	Accurate	
5. Patient instructions									
	Inappropriate	__	__	__	__	__	__	Appropriate	
6. Adjustments to treatment plan									
	Inappropriate	__	__	__	__	__	__	Appropriate	N/A
7. Patient/client response to treatment									
	Incomplete	__	__	__	__	__	__	Complete	
8. Progress toward goals									
	Incomplete	__	__	__	__	__	__	Complete	N/A
9. Reproducible intervention based on entry									
	Inaccurate	__	__	__	__	__	__	Accurate	
10. Entries are complete									
	Incomplete	__	__	__	__	__	__	Complete	
11. Time of session: clock times or units									
	Not included	__	__	__	__	__	__	Included	
12. Entries are concise and reflect skilled PT									
	Inappropriate	__	__	__	__	__	__	Appropriate	
13. Length of time to compose each entry									
	Inappropriate	__	__	__	__	__	__	Appropriate	
14. Legibility of each entry									
	Illegible	__	__	__	__	__	__	Legible	
15. Medical/professional abbreviations									
	Inappropriate	__	__	__	__	__	__	Appropriate	
16. Corrections to entries									
	Inappropriate	__	__	__	__	__	__	Appropriate	
17. Completes SOAP formatted entries or narrative									
	Inaccurate	__	__	__	__	__	__	Accurate	

Section total: _____items x _____ = _____

Comments:

PERFORMS PHYSICAL THERAPY INTERVENTIONS (year 2)
Specific interventions

1. Gait Training

Technical performance of interventions

Inaccurate __ __ __ __ __ __ Accurate

2. Wheelchair Management Training

Technical performance of interventions

Inaccurate __ __ __ __ __ __ Accurate

3. Therapeutic activities:
Transfer training

Technical performance of interventions

Inaccurate __ __ __ __ __ __ Accurate

4. Balance training in the context of gait:

Technical performance of interventions

Inaccurate __ __ __ __ __ __ Accurate

Therapeutic exercise:
5. ROM: Active/active assistive

Technical performance of interventions

Inaccurate __ __ __ __ __ __ Accurate

6. ROM: Passive

Technical performance of interventions

Inaccurate __ __ __ __ __ __ Accurate

7. Strengthening - basic

Technical performance of interventions

Inaccurate __ __ __ __ __ __ Accurate

8. Stretching

Technical performance of interventions

Inaccurate __ __ __ __ __ __ Accurate

9. Technical performance of "other" interventions

Inaccurate __ __ __ __ __ __ Accurate

10. Adjusts interventions

Inappropriate __ __ __ __ __ __ Appropriate

11. Sequencing of interventions
Inappropriate __ __ __ __ __ __ Appropriate
12. Requests assistance
Inappropriate __ __ __ __ __ __ Appropriate
13. Equipment operation
Unsafe __ __ __ __ __ __ Safe N/A

Section total: _____items x _____ = _____

Comments:

General Summary:

Overall Strengths:

Areas That Need Improvement:

Plan For Improvement:

Student Signature: _____

Faculty Signature: _____

Date: _____