

**COURSE:** CLINICAL PRACTICUM IN SPEECH-LANGUAGE PATHOLOGY  
**SPPA471 Spring 2009**  
2 credits Time: 2:00 – 4:30 p.m., T, R

**SUPERVISOR:** Lena G. Caesar, Ed.D., Ph.D., CCC-SLP  
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**COURSE DESCRIPTION:** Supervised practice in clinical management of persons with communication disorders, including test administration and implementation of therapy programs. (AU Undergraduate Bulletin, 2007-2008).

**PREREQUISITES:** SPPA 425 and a content course in practicum area; 25 hours of observation in speech-language pathology and audiology; and permission of the instructor.

**COURSE OBJECTIVES:** There are many course objectives for the practicum student. Specific objectives will vary according to individual strengths and weaknesses of the student and his/her previous practicum experience. The ultimate objectives of this course are for the student to (a) plan and implement an effective therapy program for a client, (b) demonstrate professional writing skills, and (c) conduct him or herself in a professional manner.

**REQUIREMENTS:**

1. Attend all general practicum meetings and individual conferences as scheduled to discuss written reports, therapy activities, topics of interest, and to make presentations. These presentations may be about your client, your client's disorder, therapy methods you are or would be using, and your client's progress.
2. Depending on when your client was last evaluated, you may be completing an evaluation of your client, including a hearing screening and oral peripheral evaluation, and either screening or in-depth examination of voice, fluency, articulation, or language, as applicable. If you do an evaluation, a diagnostic report, including background information, the results of the evaluation, and recommendations for the client, will be due.
3. A **treatment plan** for the entire treatment period, including long and short term objectives, is due **one week** following your first interaction with your client.
4. A **daily therapy plan** for each therapy session you conduct (including short term objectives, antecedent events, contingent events, materials needed, and data

collection methods) is due **the day before your scheduled therapy by 12:00 noon.**

4. **Therapy (SOAP) notes** are due immediately following each therapy session. They should contain the following information:

Subjective - Client's affective state, etc.

Objective - Data collected. Include homework data.

Analysis - - Your assessment of the patient's performance during the session. This analysis should logically lead to the next session's goals.

Plan - - - - Plan of action for the next session, changes you deem necessary, other follow-up.

These are to be neatly written in ink, or typed, and turned in **immediately following your weekly INDIVIDUAL session**. After they are read and signed, they will be returned to you, for you to place in your record keeping folder.

6. Semester plans and weekly therapy notes are to be placed in your record keeping folder as soon as they are returned to you. Keep lesson plans and other information with you. Be sure to keep all information entirely confidential, and never leave a patient file or your record keeping folder laying around where other people could look at it. **You must never discuss your client with your friends or family.**
7. Attend regular therapy sessions with a client. There is no excuse for tardiness or missing therapy sessions, unless you have a doctor's note. If you are ill, you are to call the department by 8:30 a.m. It is imperative you have time to prepare your materials for the session, and it will give you time to ask last minute questions of the supervisor if necessary. **FAILURE TO BE PUNCTUAL ALL SCHEDULED THERAPY/DIAGNOSTIC APPOINTMENTS AND CLINICAL MEETINGS, WITH THE EXCEPTION OF A MEDICAL EXCUSE, WILL RESULT IN A FAILING GRADE.**
8. Perform post-testing with your client to discover progress made towards long term objectives.
9. Complete a **therapy report**, which includes the following headings:
  - \* identification information
  - \* statement of the problem
  - \* historical information
  - \* communication status at beginning of therapy (including already existing info)
  - \* current therapy goals
  - \* methods
  - \* progress
  - \* impressions
  - \* recommendations

The report, (rough draft and final draft), is to follow a specified format, must be word-processed, double-spaced and must also be written in a professional and syntactically acceptable manner. The report may require several drafts. This is an integral part of the learning process.

**NOTE:** PLEASE BE AWARE THAT YOU MAY HAVE TO WRITE MORE THAN ONE ROUGH DRAFT BEFORE AN ACCEPTABLE FORM IS ATTAINED. STUDENTS ARE EXPECTED TO MAKE CHANGES BASED ON THE INSTRUCTOR'S INPUT AND SUGGESTIONS.

**The entire portfolio containing all supporting documents along with the completion of the Summary of hours form is due either (a) one month following the final session OR (b) the last day of class, whichever is first.**

**LATE ASSIGNMENTS WILL BE READ BUT WILL RESULT IN A DEDUCTION OF POINTS (25% OF MAXIMUM CREDIT FOR EACH DAY LATE).**

11. Professional dress and conduct with your clients, their significant others, other clinicians and other staff members, is required. You are now a representative of your chosen profession, as well as of Andrews University and the clinical site who is hosting you. In keeping with the "Andrews Look", obvious jewelry may not be worn during supervised clinical practica.
12. Therapy and diagnostic materials belonging to the department or clinic that you use are to be returned in good condition to the place you got them immediately following your therapy session so that they can be quickly found by anyone who needs to use them. Your own materials are also to be collected and placed neatly away after your sessions with your client. Please do not write in the books!
13. Completion of the therapy hours record form is to be filled out before a grade can be assigned. **(This should be included in the portfolio)\*.**
14. **CONFIDENTIALITY:** Utmost confidentiality is to be maintained at all times. Clients are legally entitled to privacy, and you are to respect that. Be careful with all written materials pertaining to your clients, and do not discuss clinic matters with others than clinical personnel. **NEVER include your patient's full name on therapy assignment.**

**\*Please return to pick up the portfolio prior to your departure. You will need the documentation for grad school!!**

**Grading:** You will be rated according to attendance at group/individual meetings and therapy sessions, neat and thorough completion of written work, timeliness, professionalism and skill growth during the semester. Refer to the following list of competencies:

## Competencies:

1. Make pertinent observations of client progress and needs, and respond appropriately to them.
2. Write complete, appropriate therapy plans for every session and turn them in on time.
3. Deal consistently and appropriately with off-task behaviors.
4. Use effective verbal and nonverbal antecedent events.
5. Recognize and reinforce target behaviors.
6. Collect data accurately.
7. Be well-prepared for each session.
8. Complete well-written SOAP notes following each session and turn them in promptly.
9. Turn in professional progress notes (a summary of your SOAP Notes) after every fourth session...
10. Use Standard American English.
11. Maintain client confidentiality.
12. Utilize available resources, including your supervisor, as needed.
13. Attend all scheduled therapy/diagnostic appointments and practicum meetings on time.
14. Professionalism.

**FAILURE TO DEMONSTRATE ADEQUATE SKILLS IN THE AFOREMENTIONED AREAS WILL RESULT IN A FAILING GRADE. FAILURE TO ATTEND ALL SCHEDULED THERAPY/DIAGNOSTIC APPOINTMENTS AND CLINICAL MEETINGS (WITH THE EXCEPTION OF A MEDICAL EXCUSE) WILL RESULT IN A FAILING GRADE.**

Grades are computed by obtaining a percentage score based on the number of points obtained in relation to the number of points possible on the Evaluation of Clinical Performance form. The grading scale is as follows:

<u>Grades</u>	<u>Percentage Range</u>
A	90-100
B	80-89
C	70-79
D	65-69
F	below 65

**Therapy Materials:** Assessment materials should never be removed from the department. Students who refuse to comply with this requirement are financially responsible for covering the cost of replacement and may risk losing points for professionalism. See Therapy Guidelines Attached.