LOMA LINDA UNIVERSITY

School of Allied Health Professions

DEPARTMENT OF PHYSICAL THERAPY

Physical Therapist Assistant Program
Class of 2024

CLINICAL EDUCATION HANDBOOK

Students are required to read the enclosed information and sign a form stating that they have read and will abide by the following policies and guidelines to complete their coursework in the Loma Linda University PTA program.

Rev 09/29/2023

Policies and Procedure Manual for Clinical Education
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UNIVERSITY PRINCIPLES OF EDUCATION

University Mission:

The mission of Loma Linda University Health is to continue the healing ministry of Jesus Christ, "to make man whole," in a setting of advancing medical science and to provide a stimulating clinical and research environment for the education of physicians, nurses, and other health professionals.

University Vision:

Transforming lives through education, healthcare, and research.

University Core Values:

The University affirms these values as central to its view of education: Compassion, Wholeness, Integrity, Teamwork, Humility, Justice, and Excellence.

SAHP Mission:

Loma Linda University School of Allied Health Professions is committed to creating a globally recognized, world-class learning environment where students are taught in the manner of Christ.

SAHP Vision:

We envision an environment that enables learners to lead, to heal, to serve, to touch the world in a way that transforms lives.

SAHP Purpose:

To prepare our graduates to be employees of choice for premier organizations around the world, by providing them with practical learning experiences through partnerships with those open to sharing our vision.

Department of Physical Therapy Clinical Education Mission Statement:

As part of a faith-based and diverse institution, we strive to improve the human movement experience and quality of life by advancing physical therapy practice through education, scholarship, and professional service.

Section 1: GENERAL POLICIES

ACADEMIC CONSIDERATIONS

Each student's record is reviewed quarterly by the faculty. Promotion is contingent on satisfactory academic and professional performance and on factors related to aptitude, proficiency, and responsiveness to the established aims of the school and of the profession. As an indication of satisfactory academic performance, the student is expected to maintain the following minimum grade point average: associate programs - 2.0; doctoral degree programs - 3.0.

Required Clinical Courses
Supervised clinical experience is obtained in a variety of settings, and at different times during each of the programs in the Department of Physical Therapy as follows:

- Physical Therapist Assistant Program – three [3] six-week clinical experiences (CE)
- Each clinical experience should average forty hours per week.

INTERNATIONAL CLINICAL EXPERIENCES

All clinical experiences are to be completed within the United States of America. Facilities that are in a USA commonwealth will be considered on a case-by-case basis by the Physical Therapy Department Clinical Education Committee.

PROFESSIONAL BEHAVIOR EXPECTATIONS

Student behavior reflects on the School of Allied Health Professions, Loma Linda University. Students are expected to follow ethical and professional standards. They must follow the Physical Therapy Department dress code unless directed otherwise by their Director of Clinical Education (DCE) (see Dress Code in Appendix One).

Tardiness is **NOT** acceptable behavior and will influence the student's evaluation in a negative manner.

Students are guests in the clinical facilities. They are expected to carry out assignments safely and competently according to procedures demonstrated in class and/or the clinic. If the student feels a procedure is unsafe, contraindicated, or if they are not prepared to perform it safely, they must report this to their clinical instructor (CI). A patient should not receive treatment until the physical therapist or physical therapist student has done an initial evaluation.

As an indication of satisfactory professional behavior, students are expected to demonstrate attributes, characteristics and behaviors that are not explicitly part of the professional core of knowledge and technical skills but are nevertheless required for success in the profession. The APTA has identified behaviors that are integral to the administration of physical therapy services. These behaviors are described below.

VALUES-BASED BEHAVIORS FOR THE PHYSICAL THERAPIST ASSISTANT
HOD P06-18-26-34 [Position]

The values-based behaviors for the physical therapist assistant are altruism, compassion and caring, continuing competence, duty, integrity, physical therapist-physical therapist assistant collaboration, responsibility, and social responsibility. The values-based behaviors are defined as follows:

 Altruism
Altruism is the primary regard for or devotion to the interest of patients and clients, thus assuming responsibility of placing the needs of patients and clients ahead of the physical therapist assistant's self-interest.

 Compassion and Caring
Compassion is the desire to identify with or sense something of another's experience; a precursor of caring. Caring is the concern, empathy, and consideration for the needs and values of others.

 Continuing Competence
Continuing competence is the lifelong process of maintaining and documenting competence through ongoing self-assessment, development, and implementation of a personal learning plan, and subsequent reassessment.1

 Duty
Duty is the commitment to meeting one's obligations to provide effective physical therapist services to individual patients and clients, to serve the profession, and to positively influence the health of society.

 Integrity
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.

 Physical Therapist-Physical Therapist Assistant Collaboration
The physical therapist-physical therapist assistant team works together, within each partner's respective role, to achieve optimal patient and client care and to enhance the overall delivery of physical therapist services.

 Responsibility
Responsibility is the active acceptance of the roles, obligations, and actions of the physical therapist assistant, including behaviors that positively influence patient and client outcomes, the profession, and the health needs of society.

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

REFERENCES:
1 Federation of State Boards of Physical Therapy. Continuing Competence Model. https://www.fsbpt.org/ForCandidatesAndLicensees/ContinuingCompetence/Model/. Accessed July 2, 2010.

Explanation of Reference Numbers:
HOD P00-00-00-00 stands for House of Delegates/month/year/page/vote in the House of Delegates minutes; the "P" indicates that it is a position (see below). For example, HOD P06-17-05-04 means that this position can be found in the June 2017 House of Delegates minutes on Page 5 and that it was Vote 4.
P: Position | S: Standard | G: Guideline | Y: Policy | R: Procedure
Last updated: 8/30/2018

LEGAL AND ETHICAL PRACTICE

A description of professional behavior would not be complete without the *Standards of Ethical Conduct for the Physical Therapist Assistant* as outlined by the American Physical Therapy Association, hereafter referred to as the Association, considered binding on physical therapists/physical therapist assistants who are members of the Association. Student membership in this Association is required by the Department of Physical Therapy for both physical therapist and physical therapist assistant students. (See Appendix One for the Physical Therapist *Standards of Ethical Conduct for the Physical Therapist Assistant* and the *APTA Guide for Conduct of the Physical Therapist Assistant*).

ESSENTIAL FUNCTIONS

The practice of Physical Therapy is unique and requires the professional to possess skills and physical abilities that would allow effective participation in the didactic as well as clinical components of the education. These Essential Functions are delineated in program-specific documents found in Appendix One.

Section 2: CLINICAL EDUCATION POLICIES

ASSIGNMENT OF CLINICAL EXPERIENCES

"The academic coordinator of clinical education or a designee plans and schedules all clinical assignments. Because of the limited number of local facilities available, assignments cannot be made on the basis of the student's family/marital status or personal preference. Although the department makes an effort to accommodate the student's preference, the student agrees to accept the clinical assignments made by the department at any of the affiliated facilities, whether local or out of state. Students should expect that at least one rotation will be beyond commuting distance from Loma Linda University. Many clinical sites will require the student to have a current flu vaccine if the rotation is during the flu season. Therefore, the University requires that all students receive the flu vaccine on a yearly basis." *LLU Online Catalog, Physical Therapy, 2019-2020.*

The Physical Therapy Department uses a lottery system for student selection of pre-arranged clinical slots. Students also have the option of placing a Special Request for a site that is not a pre-arranged clinical slot. This may be an existing or new contract. **The DCE will make the decision as to whether a contract with a new site is pursued on this student's behalf.**

The *School of Allied Health Professions Policy Handbook* provides guidelines for clinical assignments when a question of fitness for duty or accommodation occurs, such as medical conditions, emotional instability, pregnancy, or incompetent immunological systems (see Appendix One).

Required Settings for Clinical Experiences

Program	**Clinical Experiences**	Length
PTA	One Outpatient Orthopedic One Inpatient One Elective (any setting)	6-weeks each

Each clinical experience should average 40 hours per week. Occasionally, the Clinical Education Committee may approve collaboration with a clinical facility that can only provide a minimum of 35 hours per week. The PTA student must satisfactorily pass all three clinical experiences to qualify for completion of the PTA Program. If a clinical experience occurs in two or more settings, a minimum of 75% time spent in one setting is required to classify it as that setting.

General Goals for clinical education experiences:

- To provide learning experiences for students in a wide variety of patient types and clinical settings representing a broad cross-section of current physical therapy specialties and practice.
- To prepare the student as a generalist in the profession, equipped to add specialization to a broad and solid foundation as entry-level professionals in any practice arena.

General Guidelines:

- PTA clinical experiences will include one inpatient setting and one outpatient orthopedic setting. One of the three clinical experiences may be in a specialty area such as, Acute, Geriatric, Neuro, Orthopedics, Pediatrics, Sports Medicine, Wound Care, Cardio-Pulmonary, etc.

- Students **may not** attend two clinical experiences at the same facility.

- LLUH facilities: Clinical experiences are limited to one clinical experience for PTA students.

- Students are NOT assigned to a clinical experience in a facility where there is any potential for conflict of interest. This may include but not be limited to a facility where a relative or significant other is employed as a PT, PTA, or in an administrative position over the physical therapy department. Potential conflict of interest will be reviewed by the Clinical Education Committee as needed.

- Students are NOT assigned to facilities where they are either currently employed or have been employed in the last 5 years. Students will be held accountable for revealing such information to their DCE prior to the assignments. Failure to reveal this information will lead to disciplinary action by the Department of Physical Therapy Clinical Education Committee and may result in dismissal from the Program.

- Students are NOT to engage in fraternization with their CI or other staff at the facility during the time of the clinical experience.

STUDENT COMMUNICATION WITH CLINICAL FACILITIES AND PROGRAM

Unauthorized Contact:
Under **no circumstance** is a student, parent, family member, or friend of a student **to contact** a Facility Director, Site Coordinator of Clinical Education (SCCE), Clinical Instructor (CI), or other staff in any facility with which LLU SAHP holds an affiliation agreement **for any reason without specific permission of the appropriate DCE**. **All communication to request placement for a clinical course with contracted facilities must be done by the DCE**. A student **WILL NOT** be placed in a facility if there is evidence that any person other than the DCE has contacted the facility to request clinical placement.

If a student makes unauthorized contact with a clinical facility, disciplinary action(s) will be taken which may include but are not limited to:

- Deferment of the clinical course to a later time.
- Removal from the degree program due to unprofessional and unethical behavior.
  The disciplinary action will be decided upon by the Clinical Education Committee and presented in writing to the student.

Authorized Contact:
If a student is interested in a facility that is **not on the current contract list**, the student must discuss a Special Request for placement with the respective DCE. **Limited authorization may be granted for the student to make an initial inquiry to collect information regarding possible interest at the clinical site in accepting students for clinical education.**

Hello, my name is _____ and I'm a DPT/PTA student at Loma Linda University. I'm wondering if your facility currently takes students for clinical experiences.

If YES: *Will you please give me the name and contact information (email/phone) of the person responsible for organizing clinical experiences so that I can share it with my Director of Clinical Education?*
If No: *Is there a possibility that this facility would consider taking a student for a clinical experience?*
If YES: *Will you please give me the name and contact information (email/phone) of the person responsible for organizing clinical experiences so that I can share it with my Director of Clinical Education?*
If NO: *Thank you for your time.*

Required Contact:
Unless directed otherwise by the DCE, each **student is required to contact the SCCE/CI for final details at least four weeks prior** to the beginning of any clinical rotation.

Critical Communication

In an emergency, the student must:

- Notify the SCCE, CI, or Supervisor at the facility of the clinical experience.
- Notify the DCE or Program Director.

If the student is ill or unable to go to the clinic facility as assigned for any reason the student must:

- Call the CI or SCCE prior to the start time that day.
- Call the DCE or Program Office Secretary informing them of the absence on the same day as the absence. Report all serious illnesses to the LLU Risk Management Student Insurance Claims Examiner – James Mendez 909-558-1000 ext. 58113. The general office extension is 14010.
- Arrange for "make-up" time with the SCCE/CI and DCE.
- A physician's note is required for absences of three or more consecutive business days or ER visits and must be given to the SCCE, CI, and DCE.
- In the event of injury to a patient or the student, the student must:
  - Report the incident to the SCCE and CI immediately and to the Program DCE.
  - The DCE will report any incident that involves injury to a patient to the LLU Risk Management Liability/Casualty Manager, 909-558-1000 ext. 14010.

If time is lost from the clinical experience or the experience was postponed due to a serious medical condition:

- **The student should give both the SCCE/CI and the DCE a physician's note** before he/she can either return to the clinical facility or start the postponed clinical experience.

If unexpected clinical problems develop:

- For patient-related problems (e.g., treatment protocols, scheduling issues, incidents involving patients, institutional procedures), the student should communicate first with the CI to identify the problem and work together to resolve the situation.
- If the problem persists, the student will consult with the SCCE and the DCE.
- For interpersonal problems with the CI or other staff, the student may contact the DCE for help in addressing the problem. If the student is not able to solve the problem within the clinic, the DCE shall be contacted for consultation and an intervention from the school is appropriate.

Contact	PTA Clinical Experiences
Director of Clinical Education	**Jenni Rae Rubio** W: 909 558-4632 x47208 Email: jrubio@llu.edu
Program Director	**R. Jeremy Hubbard** W: 909 558-4632 x47254 Email: rjhubbard@llu.edu
Department Chair	**Larry Chinnock** W: 909 558-4632 x47251 Email: lchinnock@llu.edu

RESPONSIBILITIES OF THE UNIVERSITY AND PROGRAM

Students remain under the jurisdiction and responsibility of the University during clinical experiences. This includes but is not limited to:

- Require students to register for clinical experiences. Registered students are therefore covered by a health insurance and liability insurance plan. *(Refer to the letter from Risk Management in Appendix One).*
- Require that each student has an annual background check.
- Require all students have completed the required health screens.
- Require all students to abide by the policies and procedures of the clinical site while at the site and using its facilities. Providing final grade assignments for clinical experience.
- Provide all students with an identification badge and name tag.
- Provide a primary point of contact, i.e., the DCE or designee, for student assignment and planning for participation in and monitoring while on the clinical experience.

RIGHTS, PRIVILEGES, AND RESPONSIBILITIES OF THE CLINICAL EDUCATION SITE

Clinical Site
The clinical site is an environment in which physical therapy rendered is typical of the scope of practice. Loma Linda University (the University) negotiates legal affiliation agreements with each clinical facility or group whereby the students have access to clinical experiences. These contracts may vary slightly between each facility and organization but have the same basic premise of agreement.

Clinical Education Faculty (CEF)
The Clinical Education Faculty are the Site Coordinator of Clinical Education (SCCE) and Clinical Instructor (CI). The SCCE is the primary contact for the Program and coordinates and manages the student's learning experience in the clinical setting. The DCE relies on the SCCE to assign the student to the CI with consideration for achieving the most successful outcome. The SCCE maintains the Clinical Site Information Form (CSIF) which may be a source to the Program to provide current background and qualifications of the CI and general information related to the site. The primary CI is a licensed physical therapist/physical therapist assistant with a minimum of one year of clinical experience. The Program recognizes that in some clinical sites, the same individual may serve as SCCE and CI.

Clinical Education Faculty are expected to:

- Comply with regulations for practice as identified by the professional organization and governing agencies.
- Have a minimum of one year of clinical experience if acting in the role of primary Clinical Instructor.
- Provide student orientation to setting and communicate expectations and responsibilities early in the clinical experience.
- Provide ongoing constructive feedback of student performance with consideration of student's learning styles and needs and which stimulates collaborative learning.
- Evaluate the student according to the guidelines and tools provided by the program and complete documentation in accordance with identified schedule.
- Communicate with the Program DCE in a timely manner regarding student issues.
- Provide clinical education learning experiences within a safe environment, with a caseload that is representative of the physical therapy/physical therapist assistant scope of practice and allows the student to practice skills learned in the Program.

- Demonstrate ongoing desire and skill in providing clinical instruction to students and continuing professional development.

Clinical Education Faculty Development
The CI is a licensed physical therapist/physical therapist assistant with a minimum of one year of clinical experience.
The Program strongly encourages the ongoing pursuit of continuing education for SCCEs and CIs.
The Program recognizes that in some clinical sites, the same individual may serve as SCCE and CI.
SCCEs and CIs who remain current in their area of practice, knowledgeable regarding healthcare trends and avidly utilize resources for professional and personal development possess an advantage in being more effective teachers. In addition to participation in local PT clinical education forums, the Clinical Education faculty may benefit from reviewing APTA guidelines for development at:

https://www.apta.org/search?q=development+of+clinical+education+programs

https://www.apta.org/for-educators/assessments/pt-cpi [scroll down to hyperlink addressing appropriate trainee]

Responsibilities of Clinical Education Site include the following:
- Provide suitable clinical learning experiences as prescribed by the Program curriculum and objectives.
- Designate appropriate personnel to coordinate the student's clinical learning experience. This designate shall be called the Clinical Education Supervisor or Site Coordinator of Clinical Education (SCCE).
- Provide of all equipment and supplies needed for clinical instruction at the clinical site.
- Provide necessary emergency care or first aid by an accident occurring at the facility.

Rights and Privileges of the Clinical Education Faculty (CI/SCCE)
University Standard: The standard affiliation agreement signed by the facility and the University outlines the rights and privileges of the clinical education faculty including, but not limited to:
- The right to designate the individual from their staff who will coordinate the student's clinical learning experience at the facility.
- The right to receive assignment of only students who have satisfactorily completed the prerequisite didactic portion of the curriculum.
- The right to recommend withdrawal, and/or exclude, any student from its premises.

Program Standard: The faculty and staff of the Program recognize the contribution of CEF. With the goal of fostering a mutual relationship of professional development, several additional rights and privileges have been extended to them:
- Clinical education faculty are offered attendance to LLU PT hosted continuing education courses at a discounted rate.
- The Program provides documented verification of hours earned towards CEU credit (consistent with the licensing board criteria) for providing clinical instruction to the students.
- The Program provides sponsorship to a number of clinical education faculty to the APTA Clinical Instructor credentialing courses annually.
- Clinical education faculty have increased access to professional forums such as CEF and CEF-IACCC combined meetings via announcements and facilitated processes made by the Program. These forums offer additional opportunities for individual input to the development of the Profession as well as personal professional growth.
- The clinical education faculty has a right to provide feedback to the Program regarding program development and community perspectives related to the PT scope of practice.

COMMUNICATION BETWEEN CLINICAL FACILITY AND ACADEMIC PROGRAM

Schedule of Communication between the DCE and SCCE/CI:

- The DCE/designee sends an annual request form in March to the SCCE requesting a commitment to provide specific clinical experiences for the following year or to defer until slots are requested by the DCE as needed. Upon assignment of a student to a specific slot, a confirmation notice is sent to SCCE. Best efforts are made to complete this assignment and confirmation process 10-12 weeks prior to the experience.
- Approximately 6-8 weeks prior to the start of the clinical experience, a standard student information packet is sent to the SCCE. ***The Program expects the SCCE to use care in sharing the student's personal information on a "need to know" only basis.***
- The student contacts the SCCE at least 4 weeks prior to the start of the clinical experience to introduce self and to discover specific expectations for practice at the site. The student then completes any additional requirements.
- If an offered clinical slot is not assigned to a student, the DCE/designee sends a letter of cancellation to the SCCE 3-4 weeks before the start date.
- The DCE or faculty designee contacts the SCCE and/or CI 2-3 weeks prior to the midterm to schedule a midterm performance review session The SCCE/CI is expected to contact the DCE for resolution of problems at any time during the clinical experience as needed.
- The student is responsible for returning the required completed documents to the DCE at the end of the clinical experience. The CI is expected to complete the documentation by the final day of the clinical experience.
- The Program provides documented verification of hours earned towards CEU credit (consistent with the licensing board criteria) for providing clinical instruction to the students. These are sent to the clinical sites approximately six weeks after the clinical experience.
- **Student *Accommodations:*** If a student is granted approval by the School for accommodations or needs special supervision, the DCE discusses these needs with the SCCE prior to confirmation of the clinical experience. If special needs are discovered or become necessary while in the clinic, the SCCE/CI is to notify the DCE immediately.

Feedback:

Feedback from the Clinical Education Faculty to the Program includes the following:

- During the midterm visit of clinical experiences and at the end of clinical experiences. Feedback regarding the Program's preparation of the student for practice in the specific setting is discussed and documented.
- Completion of a brief survey regarding the Program's functions and processes at the end of the clinical experiences.
- During Community Advisory Council meetings and more detailed surveys distributed at other intervals as deemed necessary by the Program DCE and Program Director.

Feedback from the Program and Student to the SCCE/CI includes the following:

- Students are expected to give formal feedback to the DCE and the CEF regarding the clinical experience via The *Physical Therapist Student Experience Evaluation Form and Clinical Instruction* form. It is recommended that the SCCE/CI keep a copy which may be used for self-assessment and development. The DCE may choose to follow up on information provided via this tool at the time of the midterm visit or otherwise as appropriate.
- During the clinical experience midterm visit/review, the DCE or faculty designee observes the clinical

environment and provides feedback which may enhance the teaching/learning experience.

- The Program provides, as deemed appropriate, general announcements and information regarding the University and Program to clinical education faculty via either written, verbal, or online communications.
- The DCE or designee presents information accumulated through SIG meetings such as IACCC-CEF annual meeting.
- The DCE obtains information regarding post-professional educational needs of the CIs via course evaluation surveys at Program sponsored continuing education events. Assessment and development of educational opportunities are communicated to the CEF via email and the University website.

POLICY FOR COMPLAINTS

Complaints

Outside Complaints or Grievance Procedures

The Physical Therapist Assistant Program at Loma Linda University values comments and concerns from the outside public, in regard to the behavior of our students. We strive to graduate competent, compassionate, and ethical students. These behaviors should carry with the student past the clinic doors.
Any grievance made will be responded to and dealt with in a timely and appropriate manner.

Procedures and Responsibilities

Complaints can be made in writing through email or anonymously over the phone.
The Director of the Physical Therapist Assistant Program will manage the complaint and respond in a timely manner. Depending on the gravity of the complaint, a committee may be created to hear the complaint, and a vote taken to decide the student's standing in the Physical Therapist Assistant Program. Legal counsel will be consulted when deemed appropriate.

Students with complaints are advised to follow the steps below, in consecutive order, to resolve any program-related complaints. If the complaint remains unresolved at any level, the student may proceed to the next level.

Responsible Party:

1. Instructor/coordinator of the course – Jenni Rae Rubio at jrubio@llu.edu 909-558-4632 ext. 47208
2. Program Director – Dr. Jeremy Hubbard at rjhubbard@llu.edu, ext. 47254
3. Chair of Department of Physical Therapy – Dr. Larry Chinnock at lchinnock@llu.edu, ext. 47251
4. Dean of the School of Allied Health Professions – Dr. Craig Jackson ext. 44545

ASSESSMENT OF STUDENT LEARNING IN CLINICAL SETTING

Clinical Experiences (LCEs)

Clinical Education is a critical component of a Physical Therapist Assistant Education. Like most healthcare and allied health professions is dynamic in nature. Professional task forces and special interest groups continue to provide input to develop models of clinical assessment which are more and more efficient and valid in representing student performance and program outcomes.

Assessment Tool:

APTA Physical Therapist Assistant Clinical Performance Instrument (APTA CPI 3.0):

The student completes a self-assessment.
The CI completes an assessment of the student.

The student receives instruction in the use of the assessment tool and is expected to collaborate with the CI in setting performance goals and to allow for self-reflection and self-development. The tool contains 11 criteria that are used to assess student performance at the midterm and final evaluations.

In addition to online resources via links in the letter of instructions to the CI, instructions for the use of the CPI tool are located in the student's Clinical Experience Manual. Clinical Instructors and students are instructed to complete the online APTA training as found on the APTA Online Learning Center prior to completion of the performance assessment: https://www.apta.org/for-educators/assessments/pt-cpi. Scroll down page to access the link for the appropriate trainee.

Vendor support may be accessed at email: cpi@apta.org; phone 703-706-8582

Midterm reviews: Key academic faculty are assigned to each student for review of the student's performance with the student and CI at midterm. Completion of the CPI for the midterm is highly encouraged to allow a more meaningful and efficient discussion and problem-solving as needed.

Specific standards for satisfactory completion of each clinical experience.
See Appendix Two or Individual Course Outline included in the informational packet for the student.

While the expectations for student performance increases with successive clinical experiences, some students perform at a level above the required standard for their particular experience. The CPI provides a mechanism for indicating such performance described as "Beyond Entry-level Performance".

In addition to the summative discussion and documentation of the student's performance presented at midterm and final evaluation periods, the program highly recommends that the CI provides additional student feedback as needed to foster ongoing professional development.

Procedures for Final Assessment of Clinical Experiences:

1. Evaluation of student by the CI (includes documentation using the APTA CPI).
2. Student Self-assessment using the APTA CPI.
3. Student submission of other program assignments (see CI instruction letter or Course outline)
4. Documentation of midterm Reviews by academic faculty with the CI and the student.

Learning Objectives for Clinical Experiences:
The following objectives correspond with the CAPTE Standards & Required Elements listed.

At the completion of the course, CE I, CE II, or CE III, the student will demonstrate performance on all Physical Therapist Assistant APTA CPI 3.0 criteria 1-11 at or above the standard set by the program for the specific experience (See specific Course Outline or Appendix Two for *Standards of Satisfactory Completion of Clinical Experience*).

Professionalism

1. Physical Therapist Assistant CPI criteria 1: Ethical Practice
2. Physical Therapist Assistant CPI criteria 2: Legal Practice
3. Physical Therapist Assistant with CPI criteria 3: Professional Growth

Interpersonal

4. Physical Therapist Assistant CPI criteria 4: Communication
5. Physical Therapist Assistant CPI criteria 5: Inclusivity

Technical/Procedural

6. Physical Therapist Assistant CPI criteria 6: Clinical Reasoning
7. Physical Therapist Assistant CPI criteria 7: Interventions: Therapeutic Exercise and Techniques
8. Physical Therapist Assistant CPI criteria 8: Interventions: Mechanical and Electrotherapeutic Modalities
9. Physical Therapist Assistant CPI criteria 9: Interventions: Functional Training and Application of Devices and Equipment

Business

10. Physical Therapist Assistant CPI criteria 10: Documentation
11. Physical Therapist Assistant CPI criteria 11: Resource Management

CRITERIA AND PROCEDURES
FOR SUCCESSFUL COMPLETION OF CLINICAL EXPERIENCES

Grading and Intervention (The entire PTA Grading Policy may be found in Appendix Two).

The following includes resources for grading of the clinical experiences:

1. Physical Therapist Assistant Clinical Performance Instrument (CPI)
2. Interviews conducted by academic faculty reviewers with the Site Coordinator for Clinical Education (SCCE), Clinical Instructor (CI), and the student.
3. Student's *Self-Assessment* using *the Clinical Performance Instrument Form.*

Students are expected to demonstrate attributes, characteristics, and behaviors that are not explicitly part of the professional core of knowledge and technical skills but are nevertheless required for success in the profession. The APTA has identified behaviors [Core Values/Values-based behavior] that are integral to the satisfactory completion of a clinical experience. The CEC will reference these APTA sources to substantiate the decision for grading as deemed necessary.

Each student is expected to receive a satisfactory rating by the end of each clinical experience. Each rotation is independent of the others and must be satisfactorily completed.

Challenges with meeting expectations

If the clinical faculty (SCCE/CI) finds that the student is not meeting the requirements or expectations for the clinical experience, the SCCE/CI should contact the DCE to develop an agreeable plan of action for successful completion. The student is also encouraged to contact the DCE in this regard. Periodic review and specific feedback from the CEF should be provided to the student and the DCE. If the problem remains unresolved, the Clinical Education Committee (CEC) will review the case and provide input up to and including immediate termination of the clinical experience. A clinical facility also has the right to terminate an experience at the discretion of the CEF and/or administration. Errors in safety and/or judgment and unprofessional behavior may be grounds for the student to be removed from the facility. **A student who chooses to terminate any clinical experience without consultation and approval from the respective DCE will automatically receive an "Unsatisfactory" grade** for the clinical experience.

The Clinical Instructor does not determine the final grade for clinical experiences. If the student is at risk of receiving an unsatisfactory grade, the CEC will review the indicators listed above and will determine the final grade.

The *DPT Clinical Education Committee* is comprised of the following: DCEs from PT and PTA Programs, Program Directors of PT and PTA, and two additional faculty designates from the Academic Faculty who perform PT Midterm reviews, as representation of the PT faculty. The *PTA Clinical Education Committee* consists of the following: the DCE from the PTA program, the Program Directors of PT and PTA, and two PTA faculty members. The DCEs from the DPT program will be part of the PTA CEC as needed. The Clinical Education Committees have the right to obtain additional input from other faculty in assessing the overall student performance and assigning the grade.

Timely submission of clinical documents to the DCE by the student is critical to facilitate timely review and grade assignment. If the student fails to complete and submit the required documents including CPI, Student Evaluation of Clinical Experience (SECE) form, In-service/Project Report, Reflection Summaries, and all appropriate signatures and dates, by 5:00 p.m. on the MONDAY after the last scheduled date of the clinical experience, an **"Unsatisfactory" (U) grade will be submitted. A "U" grade entered under these conditions must be remediated by submission of completed documents and a re-registration fee for the clinical experience.**

Scholastic Disqualification Policy

- The Program has a policy regarding disqualification based on scholastic performance throughout the Program. According to the PTA Student Handbook,

  > Course Failure after Passing Anatomy – "There is a limit to the number of courses that a student may fail before dismissal from the program. A student is not allowed to fail more than one course throughout the program, **regardless of the units** of the course, during the remainder of the program after PTA Anatomy (all of which must be remediated). Each failure of a course accounts for one failure disqualification point, regardless of units. **A failure of more than one course** (2 disqualification points or more) results in **academic dismissal** from the program regardless of remediation measures. Students in the program must receive a grade of C or better in all subjects to complete the program. Grades of C-, D, or F are considered failing grades in the PTA Program. If a student fails one course (and no more than one) the course may be remediated and the student may remain in the program according to the process below. If the student successfully remediates the course, it still counts as one point from a failed course" *LLU Physical Therapist Assistant Student Handbook, 2023-2024.*

- A student who fails only one course throughout the Program regardless of units results in remediation measures from the Program. According to the PTA Student Handbook,

  > Remediation – "If a student fails any PTAS course in winter term, they will not be allowed to progress to *PTAS 293 PTA Clinical Experience I* in spring term. The student is allowed to progress to the didactic courses in the normal PTA curriculum in spring term while remediating the failed course. Under these circumstances, all didactic courses must be satisfactorily completed prior to progression to any full-time clinical experience. The three full-time clinical experiences would be postponed and rescheduled pending satisfactory completion of all didactic courses" *LLU Physical Therapist Assistant Student Handbook, 2023-2024.*

- When a student repeats a course in which he/she received an unsatisfactory grade, even if the student has completed remediation for the course and the grade was changed from "F" to "C", and he/she fails a clinical experience disqualifies him/herself from the Program.

- Late assignments and paperwork during a clinical experience will result in an Unsatisfactory (U) grade (which remains on the transcript), however, does not qualify as a failure toward disqualification points. An Unsatisfactory grade under this condition will require the student to remediate the course by submitting the completed documents and re-register for the specified Clinical Experience at a fee of $250.00 to receive a Satisfactory (S) grade.

Section 3: STUDENT RESPONSIBILITIES

STUDENT RIGHTS AND ACCESS TO BENEFITS
These resources are detailed in the University Student Handbook as well as the Student Handbook for the Physical Therapist Assistant Program.

STUDENT RESPONSIBILITIES
This section contains the individual responsibilities of the PTA student as they relate to the clinical setting. Compliance with these policies and responsibilities is necessary for satisfactory completion of each clinical experience.

Health Policies – All students must have the following on file with the DCE or designee:

TB Test – (Tuberculosis Screen)
Documentation of the TB test must be current within 1 year prior to starting a clinical experience. Some clinical sites may require a two-step test or a test within a shorter time. If the TB test is positive, a copy of the chest X-ray report must be on file.

Hepatitis B Vaccine – Documentation for 3 vaccinations or a report of a positive antibody titer.

MMR - (mumps, measles, and rubella vaccine) - Documentation of two immunizations or a report of a positive antibody titer.

TDAP – Tetanus, Diphtheria, and Pertussis. Documentation of inoculation within the last ten years.

Varicella (chicken pox) – Proof of a positive varicella titer or a series of two vaccinations. Some clinical sites require a titer.

Seasonal Flu – Documentation of influenza vaccination for the current flu season, October – March.

Site Specific – There may be other additional health records that are required by some clinical facilities. The student is to consult with the DCE or designee for any specific requirements. Facilities may require titers for Hepatitis B, MMR, and Varicella (chicken pox), and proof of COVID-19 vaccination. Pre-clinical or random drug testing or physical examinations may be required, as well as required site-specific testing.

Cardio-Pulmonary Resuscitation – CPR
The student must carry a current BLS CPR certification for the Health Care Worker (for adult, child, and infant) issued from the **American Heart Association** when in the clinic and a copy should be on file in the Program's clinical education office with the DCE.

Background Check
Background checks are currently part of registration preceding the student's enrollment into the Program and an updated background check may be required for the final two clinical experiences. This is to ensure that background checks are not more than 12 months old when the student begins a clinical experience. The

background check is completed via the student portal of the University and accessed by an administratively designated individual in the School.

As per the website, "The background package has been designed to meet the clinical placement requirements for all Loma Linda University medical programs and their associated clinical placement facilities." Some clinical facilities may require additional background checks done by the student or fingerprinting through their own vendor at the student's expense.

The student is advised that while the result of background checks may allow entrance to particular clinical sites during the course of the program, there is no guarantee that this would allow satisfactory completion of the application for licensure. Each background check for application for state licensure is assessed individually by the state's own licensing body.

Student Clinical Education Resources and Materials

Students access resources for orientation and training through the program and course-specific Canvas resources, department resources on Canvas (Clinical Education Resources Archives – CERA), and EXXAT.com database. Information includes, information regarding the Professional organization pertaining to student experiences in the clinic, clinical site information and contact personnel, feedback from previous students, instructions and guidelines on preparation for the clinical environment, including instructions for use of these resources are presented to the students during Orientation to Clinical Education sessions and is provided during the clinical orientation classes by the DCE and support staff.

Students have access to view their rotation placement process using the web application: EXXAT.com where they can follow up on special request statuses, onboarding requirements, and rotation placement details. Additionally, clinical course-specific orientation, instructions, and assignments are found in CANVAS for those courses.

Biographical Form

The *biographical information* is found on the student's profile page in the Exxat tool. This information is crucial for both the DCE and the clinical education faculty. It will be sent to each student's clinical experience sites.

- Each student must complete an electronic biographical form on Exxat by the given date as instructed by the DCE.

- The student is responsible for updating and keeping current all information on Exxat – Student Profile page.

Confidentiality and Protected Information

The Department of Physical Therapy recognizes that information that promotes effective student education and patient/client care may be shared with appropriate individuals. Reasonable care is expected in the dissemination and use of this information in arranging for clinical experiences. Students document acknowledgment of this sharing of information with the Program.

Students receive instruction in the basics of the Health Information Portability and Accountability Act (HIPAA) early in the program, but it is reasonable to expect some clinical sites to include additional training during their orientation.

Policies regarding patient/client rights within the clinical setting are established by that institution and should allow the patient/client the right to refuse to participate in clinical education. Students are expected to adhere to these policies while at the clinical site.

TIMELINE OF STUDENT RESPONSIBILITIES

PRIOR TO THE CLINICAL EXPERIENCE, THE STUDENT WILL:

- Attend all **Clinical Orientation classes** per program.

- Submit documentation of all **health requirements and other compliance items on Exxat database** as directed by the DCE/designee.

- Complete a student **Profile page on Exxat** as instructed by the DCE.

- Access all **pertinent information** needed for clinical experiences from the DCE/designee in a timely manner. Respond to emails in a timely fashion to ensure sufficient time for a successful onboarding process.

- **Contact the facility not later than four weeks before the start of the experience (or as otherwise directed by the DCE)** to communicate with the SCCE/CI and to ensure their receipt of access to the student packet and obtain information on any additional requirements, such as work schedule, directions to the facility, dress code, etc.

- Complete any **additional site-specific requirements.** Failure to complete and/or submit requirements on time may be subject to disciplinary action up to and including a fee assignment or deferral of attendance to the current clinical experience.

PRIOR TO AND/OR DURING THE CLINICAL EXPERIENCE, THE STUDENT WILL:

- **Make arrangements for reliable transportation to the clinical facility.**
  The student is responsible for housing as well as transportation to and from the facility, whether by his/her own transportation, carpooling, or public transportation. Students may expect to travel up to 70 miles from residence to attend a clinical experience(s). Some sites may offer stipends, but this is a privilege and not a right to be expected. Any hours lost due to absences and/or tardiness because of car trouble may need to be made up.

- **Arrive on time each day.**
  Each student must clarify the work schedule with the SCCE/CI prior to starting the clinical experience. Clinic hours may vary throughout the clinical experience. Students are required to complete on an average 40 hours per week with a minimum of 35 hours per week. The student is not to request an alternative work schedule with the facility. Exceptions to the assigned work schedule must be negotiated by the DCE.

- **Notify the SCCE/CI if the student expects to be late.**

- **Notify the DCE and SCCE/CI if absent for any length of time.**
  Both the DCE and CI must be notified and given the reason for the absence. The DCE/CEC will determine if the absence may be excused. Absences are for **emergencies only.** All absences must be made up within the clinical experience rotation. Make-up day(s) is at the discretion of the DCE.

  Request personal days in writing to the DCE prior to the clinical experience. The DCE will consult with the CEC and SCCE/CI to determine if the request can be approved. Excessive absences can be reason for extending or retaking clinical experiences, delayed graduation, or disciplinary action by the Program.

- **Dress professionally and abide by the dress code of the academic program and the clinical facility.** (See Appendix One for Dress Code) The student must clarify any questions regarding the dress code with the SCCE/CI prior to starting the clinical experience. If there are any questions about the appropriateness of the attire, a lab coat should be worn.

- **Wear the name badge provided by the Program** and any additional identification required by the clinical facility.

- **Introduce yourself to the patients and clinical or hospital staff as a PTA student.**
  Acknowledge the patient's right to refuse treatment.

- **Prepare adequately for the clinical experience, including case studies, in-services, and any other additional assigned "homework".** The clinical experience should NOT be considered a VACATION from school, but an advanced learning experience. Students are expected to complete all assignments given by the SCCE/CI and to prepare for in-services in a timely manner.

- **Present a minimum of one in-service/project during the clinical experiences.** The student may be required by the clinical facility to do additional in-services. In-service presentation/Project, other evaluation materials, and the report form should be submitted to the DCE at the end of the clinical experience in which it was presented. **Anytime** an In-service/Project is performed, the submission must be accompanied by the supporting paperwork.

- **Establish access to resource material** while in the clinical setting to support and guide his/her clinical decision-making, including texts, lecture materials, articles, and in-service materials.

- **Take responsibility for his/her clinical learning experience**. Make good use of "free time" by reading information pertaining to the clinical setting, preparing for the in-service, or with the permission of the CI to observe other clinicians and healthcare professionals involved with patient care.

- **Abide by the safety policy of the facility.**
  Safety policies should be covered during the student orientation of each facility. If safety policies are not covered the student is required to seek out this information.

- **Practice in a safe manner and adhere to legal and ethical standards**.
  Under no circumstance is the student to treat a patient without a physical therapist in the building. If the physical therapist has stepped out of the building for any reason, the student is not to start or continue treatment of any patient, even if directed to do so by the CI. If this situation occurs the DCE should be notified immediately.

  The student should be very careful to use safe techniques when treating patients. Good body mechanics are important and should be practiced in all situations.

  The student should inform the DCE regarding any serious problems encountered during the clinical experience, such as errors in practice, unethical, or illegal practices. Problems that involve the CI and/or problems with a patient or patient's family member should be reported to the SCCE and the DCE.

- **Discuss the use of the evaluation forms for the Clinical Performance Instrument (CPI) with the CI at the beginning of the experience.** Complete the student's version of the evaluation documents and discuss CI's assessment and feedback at the midterm and final of the clinical experience. Both the student and the CI should be proactive in the completion of all assessment documentation, but it is the student's responsibility for timely completion and submission.

- **Communicate openly with CI regarding learning opportunities, questions or differences between CI and student, and learning style and format of feedback.** If the CI and student are not able **to resolve a conflict,** the SCCE should be notified for assistance. If unresolved, the DCE should be contacted. The student, the SCCE, and/or CI may contact the DCE whenever needed.

AT THE COMPLETION OF THE CLINICAL EXPERIENCE, THE STUDENT WILL:

- **Submit all required course materials on CANVAS and Exxat as directed by DCE.** Materials submitted after the deadline will result in an "Unsatisfactory" grade and a delay in the transmission of completion notices. To remove an unsatisfactory grade, the student must re-register for the course.

- **Attend an Exit Interview with the DCE or designated Faculty Reviewer after the completion of the last clinical experience to provide overall feedback.** Onsite Exit Interviews are expected. Phone reviews may be accommodated on a case-by-case basis as approved by the DCE or Program Director.

Appendix One

Tab. 1 APTA Core Documents:
Code of Ethics for the Physical Therapist
Guide for Professional Conduct
Standards of Ethical Conduct for the Physical Therapist Assistant
Guide for Conduct of the Physical Therapist Assistant

Tab. 2 Dress Code

Tab. 3 Procedure for Evaluating Fitness for Duty – School of Allied Health Professions Policy

Tab. 4 Risk Management Letter/Health Plan

Tab. 5 Sexual Harassment Policy – Loma Linda University Policy

Tab. 6 Identification and Supervision of Physical Therapy, Physical Therapy Assistant Students

Tab. 7 Essential Functions for PT/PTA Students

Tab. 8 Medicare Reimbursement and Student Services – APTA Chart *(rev. 10-15-13)*

Code of Ethics for the Physical Therapist

Code of Ethics for the Physical Therapist HOD S06-19-47-67 [Amended HOD S06-09-07-12; HOD S06-00-12-23; HOD 06-91-05-05; HOD 06-87-11-17; HOD 06-81-06-18; HOD 06-78-06-08; HOD 06-78-06-07; HOD 06-77-18-30; HOD 06-77-17-27; Initial HOD 06-73-13-24] [Standard]

Preamble

The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). The purposes of this Code of Ethics are to:

1. Define the ethical principles that form the foundation of physical therapist practice in patient and client management, consultation, education, research, and administration.
2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.
4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.
5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

No code of ethics is exhaustive, nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive.

This Code of Ethics is built upon the five roles of the physical therapist (management of patients and clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal). Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

Principles

Principle #1: *Physical therapists shall respect the inherent dignity and rights of all individuals. (Core Values: Compassion, Integrity)*

1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

1B. Physical therapists shall recognize their personal biases and shall not discriminate against others in physical therapist practice, consultation, education, research, and administration.

Principle #2: *Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients and clients. (Core Values: Altruism, Compassion, Professional Duty*)

2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients and clients over the interests of the physical therapist.
2B. Physical therapists shall provide physical therapist services with compassionate and caring behaviors that incorporate the individual and cultural differences of patients and clients.
2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapist care or participation in clinical research.
2D. Physical therapists shall collaborate with patients and clients to empower them in decisions about their health care.
2E. Physical therapists shall protect confidential patient and client information and may disclose confidential information to appropriate authorities only when allowed or as required by law.

Principle #3: *Physical therapists shall be accountable for making sound professional judgments. 2 (Core Values: Excellence, Integrity)*

3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's or client's best interest in all practice settings.
3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient and client values.
3C. Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.
3D. Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.
3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

Principle #4: *Physical therapists shall demonstrate integrity in their relationships with patients and clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public. (Core Value: Integrity)*

4A. Physical therapists shall provide truthful, accurate, and relevant information and shall not make misleading representations.
4B. Physical therapists shall not exploit persons over whom they have supervisory, evaluative or other authority (eg, patients/clients, students, supervisees, research participants, or employees).
4C. Physical therapists shall not engage in any sexual relationship with any of their patients and clients, supervisees, or students.
4D. Physical therapists shall not harass anyone verbally, physically, emotionally, or sexually.
4E. Physical therapists shall discourage misconduct by physical therapists, physical therapist assistants, and other health care professionals and, when appropriate, report illegal or unethical acts, including verbal, physical, emotional, or sexual

harassment, to an appropriate authority with jurisdiction over the conduct.

4F. Physical therapists shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.

Principle #5: *Physical therapists shall fulfill their legal and professional obligations. (Core Values: Professional Duty, Accountability)*

5A. Physical therapists shall comply with applicable local, state, and federal laws and regulations.

5B. Physical therapists shall have primary responsibility for supervision of physical therapist assistants and support personnel.

5C. Physical therapists involved in research shall abide by accepted standards governing protection of research participants.

5D. Physical therapists shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

5F. Physical therapists shall provide notice and information about alternatives for obtaining care in the event the physical therapist terminates the provider relationship while the patient or client continues to need physical therapist services.

Principle #6: *Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors. (Core Value: Excellence)*

6A. Physical therapists shall achieve and maintain professional competence.

6B. Physical therapists shall take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.

6C. Physical therapists shall evaluate the strength of evidence and applicability of content presented during professional development activities before integrating the content or techniques into practice.

6D. Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.

Principle #7: *Physical therapists shall promote organizational behaviors and business practices that benefit patients and clients and society. (Core Values: Integrity, Accountability)*

7A. Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.

7B. Physical therapists shall seek remuneration as is deserved and reasonable for physical therapist services.

7C. Physical therapists shall not accept gifts or other considerations that influence or give an appearance of influencing their professional judgment.

7D. Physical therapists shall fully disclose any financial interest they have in products or services that they recommend to patients and clients.

7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapist services accurately reflect the nature and extent of the services provided.

7F. Physical therapists shall refrain from employment arrangements, or other arrangements, that prevent physical therapists from fulfilling professional obligations to patients and clients.

Principle #8: *Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally. (Core Value: Social Responsibility)*

8A. Physical therapists shall provide pro bono physical therapist services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

8B. Physical therapists shall advocate to reduce health disparities and health care inequities, improve access to health care services, and address the health, wellness, and preventive health care needs of people.

8C. Physical therapists shall be responsible stewards of health care resources and shall avoid overutilization or under-utilization of physical therapist services.

8D. Physical therapists shall educate members of the public about the benefits of physical therapy and the unique role of the physical therapist.

Effective June 2019

For more information, go to www.apta.org/ethics.

APTA Guide for Professional Conduct

Purpose

The APTA Guide for Professional Conduct (Guide) is intended to serve physical therapists in interpreting the Code of Ethics for the Physical Therapist (Code of Ethics) of the American Physical Therapy Association (APTA) in matters of professional conduct. The APTA House of Delegates in June of 2009 adopted a revised Code of Ethics, which became effective July 1, 2010.

The Guide provides a framework by which physical therapists may determine the propriety of their conduct. It also is intended to guide the professional development of physical therapist students. The Code of Ethics and the Guide apply to all physical therapists. These guidelines are subject to change as the dynamics of the profession change, and as new patterns of health care delivery are developed and accepted by the professional community and the public.

Interpreting Ethical Principles

The interpretations expressed in this Guide reflect the opinions, decisions, and advice of the APTA Ethics and Judicial Committee (EJC). The interpretations are set forth according to topic. These interpretations are intended to assist a physical therapist in applying general ethical principles to specific situations. They address some but not all topics addressed in the principles and should not be considered inclusive of all situations that could evolve.

This Guide is subject to change, and the Ethics and Judicial Committee will monitor and revise the Guide to address additional topics and principles when and as needed.

Preamble to the Code of Ethics

The Preamble states as follows:

> The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). The purposes of this Code of Ethics are to:
>
> 1. Define the ethical principles that form the foundation of physical therapist practice in patient/client management, consultation, education, research, and administration.
> 2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
> 3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities. APTA Guide for Professional Conduct
> 4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.
> 5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

No code of ethics is exhaustive nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive.

This Code of Ethics is built upon the five roles of the physical therapist (management of patients/clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal). Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

Interpretation: Upon the Code of Ethics for the Physical Therapist being amended effective July 1, 2010, all the lettered principles in the Code of Ethics contain the word "shall" and are mandatory ethical obligations. The language contained in the Code of Ethics is intended to better explain and further clarify existing ethical obligations. These ethical obligations predate the revised Code of Ethics. Although various words have changed, many of the obligations are the same. Consequently, the addition of the word "shall" reinforces and clarifies existing ethical obligations. A significant reason that the Code of Ethics was revised was to provide physical therapists with a document that was clear enough to be read on its own without the need to seek extensive additional interpretation.

The Preamble states that "[n]o Code of Ethics is exhaustive nor can it address every situation." The Preamble also states that physical therapists "are encouraged to seek additional advice or consultation in instances in which the guidance of the Code may not be definitive." Potential sources for advice and counsel include third parties and the myriad resources available on the APTA website. Inherent in a physical therapist's ethical decision-making process is the examination of his or her unique set of facts relative to the Code of Ethics. APTA Guide for Professional Conduct

Topics

Respect

Principle 1A states as follows:

1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

Interpretation: Principle 1A addresses the display of respect toward others. Unfortunately, there is no universal consensus about what respect looks like in every situation. For example, direct eye contact is viewed as respectful and courteous in some cultures and inappropriate in others. It is up to the individual to assess the appropriateness of behavior in various situations.

Altruism

Principle 2A states as follows:

> 2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.
>
> Interpretation: Principle 2A reminds physical therapists to adhere to the profession's core values and act in the best interest of patients and clients over the interests of the physical therapist. Often this is done without thought, but, sometimes, especially at the end of the day when the physical therapist is fatigued and ready to go home, it is a conscious decision. For example, the physical therapist may need to make a decision between leaving on time and staying at work longer to see a patient who was 15 minutes late for an appointment.

Patient Autonomy

Principle 2C states as follows:

> 2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.
>
> **Interpretation:** Principle 2C requires the physical therapist to respect patient autonomy. To do so, he or she shall communicate to the patient or client the findings of the physical therapist examination, evaluation, diagnosis, and prognosis. The physical therapist shall use sound professional judgment in informing the patient or client of any substantial risks of the recommended examination and intervention and shall collaborate with the individual to establish the goals of treatment and the plan of care. Ultimately, the physical therapist shall respect the individual's right to make decisions regarding the recommended plan of care, including consent, modification, or refusal.

Professional Judgment

Principles 3, 3A, and 3B state as follows:

> 3: Physical therapists shall be accountable for making sound professional judgments. (Core Values: Excellence, Integrity)
>
> 3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's/client's best interest in all practice settings.
>
> 3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.
>
> Interpretation: Principles 3, 3A, and 3B state that it is the physical therapist's obligation to exercise sound professional judgment, based upon his or her knowledge, skill, training, and

experience. Principle 3B further describes the physical therapist's judgment as being informed by 3 elements of evidence-based practice.

With regard to the patient and client management role, once a physical therapist accepts an individual for physical therapy services he or she shall be responsible for: the examination, evaluation, and diagnosis of that individual; the prognosis and intervention; reexamination and modification of the plan of care; and the maintenance of adequate records, including progress reports. The physical therapist shall establish the plan of care and shall provide and/or supervise and direct the appropriate interventions. Regardless of practice setting, the physical therapist has primary responsibility for the physical therapy care of a patient or client and shall make independent judgments regarding that care consistent with accepted professional standards.

If the diagnostic process reveals findings that are outside the scope of the physical therapist's knowledge, experience, or expertise or that indicate the need for care outside the scope of physical therapy, the physical therapist shall so inform the patient or client and shall refer the individual to an appropriate practitioner.

The physical therapist shall determine when a patient or client will no longer benefit from physical therapist services. When the physical therapist's judgment is that a patient will receive negligible benefit from physical therapist services, the physical therapist shall not provide or continue to provide such services if the primary reason for doing so is to further the financial self-interest of the physical therapist or his or her employer. The physical therapist shall avoid overutilization of physical therapist services. See Principle 8C.

Supervision

Principle 3E states as follows:

3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

Interpretation: Principle 3E describes an additional circumstance in which sound professional judgment is required; namely, through the appropriate direction of and communication with physical therapist assistants and support personnel. Further information on supervision via applicable local, state, and federal laws and regulations (including state practice acts and administrative codes) is available. Information on supervision via APTA policies and resources is also available on the APTA website. See Principles 5A and 5B.

Integrity in Relationships

Principle 4 states as follows:

4. Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public. (Core Value: Integrity)

Interpretation: Principle 4 addresses the need for integrity in relationships. This is not limited to relationships with patients and clients but includes everyone physical therapists come into contact with professionally. For example, demonstrating integrity could encompass working collaboratively with the health care team and taking responsibility for one's role as a member of that team.

Reporting

Principle 4C states as follows:

4C. Physical therapists shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.

Interpretation: Physical therapists shall seek to discourage misconduct by health care professionals. Discouraging misconduct can be accomplished through a number of mechanisms. The following is not an exhaustive list:

- Do not engage in misconduct; instead, set a good example for health care professionals and others working in their immediate environment.
- Encourage or recommend to the appropriate individuals that health care and other professionals, such as legal counsel, conduct regular (such as annual) training that addresses federal and state law requirements, such as billing, best practices, harassment, and security and privacy; as such training can educate health care professionals on what to do and not to do.
- Encourage or recommend to the appropriate individuals other types of training that are not law based, such as bystander training.
- Assist in creating a culture that is positive and civil to all.
- If in a management position, think about promotion and hiring decisions and how they can impact the organization.
- Access professional association resources when considering best practices.
- Revisit policies and procedures each year to remain current.

Many other mechanisms may exist to discourage misconduct. The physical therapist should be creative, open-minded, fair, and impartial in considering how to best meet this ethical obligation. Doing so can actively foster an environment in which misconduct does not occur. The main focus when thinking about misconduct is creating an action plan on prevention. Consider that reporting may never make the alleged victim whole or undo the misconduct.

If misconduct has not been prevented, then reporting issues must be considered. This ethical obligation states that the physical therapist reports to the "relevant authority, when appropriate." Before examining the meaning of these words it is important to note that reporting intersects with corporate policies and legal obligations. It is beyond the scope of this interpretation to provide legal advice regarding laws and policies; however, an analysis of reporting cannot end with understanding one's ethical obligations. One may need to seek advice of legal counsel who will take into consideration laws and policies and seek to discover the facts and circumstances.

With respect to ethical obligations, the term "when appropriate" is a fact-based decision and will be impacted by requirements of the law. If a law requires the physical therapist to take an action, then, of course, it is appropriate to do so. If there is no legal requirement and no corporate policy, then the physical therapist must consider what is appropriate given the facts and situation. It may not be appropriate if the physical therapist does not know what occurred, or because there is no legal requirement to act and the physical therapist does not want to assume legal responsibility, or because the matter is being resolved internally. There are many different reasons that something may or may not be appropriate.

If the physical therapist has determined that it is appropriate to report, the ethical obligation requires him or her to consider what entity or person is the "relevant authority." Relevant authority can be a supervisor, human resources, an attorney, the Equal Employment Opportunities Commission, the licensing board, the Better Business Bureau, Office of the Insurance Commissioner, the Medicare hotline, the Office of the Inspector General hotline, the US Department of Health & Human Services, an institution using their internal grievance procedures, the Office of Civil Rights, or another federal agency, state agency, city or local agency, or a state or federal court, among others.

Once the physical therapist has decided to report, he or she must be mindful that reporting does not end his or her involvement, which can include office, regulatory, and/or legal proceedings. In this context, the physical therapist may be asked to be a witness, to testify, or to provide written information.

Sexual Harassment

Principe 4F states as follows:

4F. Physical Therapists shall not harass anyone verbally, physically, emotionally, or sexually.

Interpretation: As noted in the House of Delegates policy titled Sexual Harassment, "[m]embers of the association have an obligation to comply with applicable legal prohibitions against sexual harassment…." This statement is in line with Principle 4F that prohibits physical therapists from harassing anyone verbally, physically, emotionally, or sexually. While the principle is clear, it is important for APTA to restate this point, namely that physical therapists shall not harass anyone, period. The association has zero tolerance for any form of harassment, specifically including sexual harassment.

Exploitation

Principle 4E states as follows:

4E. Physical therapists shall not engage in any sexual relationship with any of their patient/clients, supervisees or students.

Interpretation: The statement is clear—sexual relationships with their patients or clients, supervisees, or students are prohibited. This component of Principle 4 is consistent with Principle 4B, which states:

Physical therapists shall not exploit persons over whom they have supervisory, evaluative, or other authority (eg, patients and clients, students, supervisees, research participants, or employees).

Consider this excerpt from the EJC Opinion titled Topic: Sexual Relationships With Patients or Former Patients:

> A physical therapist stands in a relationship of trust to each patient and has an ethical obligation to act in the patient's best interest and to avoid any exploitation or abuse of the patient. Thus, if a physical therapist has natural feelings of attraction toward a patient, he or she must sublimate those feelings in order to avoid sexual exploitation of the patient.
>
> One's ethical decision making process should focus on whether the patient or client, supervisee, or student is being exploited. In this context, questions have been asked about whether one can have a sexual relationship once the patient or client relationship ends. To this question, the EJC has opined as follows:
>
> The Committee does not believe it feasible to establish any bright-line rule for when, if ever, initiation of a romantic/sexual relationship with a former patient would be ethically permissible.
>
> The Committee imagines that in some cases a romantic/sexual relationship would not offend…if initiated with a former patient soon after the termination of treatment, while in others such a relationship might never be appropriate.

Colleague Impairment

Principle 5D and 5E state as follows:

5D. Physical therapists shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report the information to the appropriate authority.

Interpretation: The central tenet of Principles 5D and 5E is that inaction is not an option for a physical therapist when faced with the circumstances described. Principle 5D states that a physical therapist shall encourage colleagues to seek assistance or counsel while Principle 5E addresses reporting information to the appropriate authority.

5D and 5E both require a factual determination. This may be challenging in the sense that the physical therapist might not know or easily be able to determine whether someone in fact has a physical, psychological, or substance-related impairment. In addition, it might be difficult to

determine whether such impairment may be adversely affecting his or her professional responsibilities.

Moreover, once the physical therapist does make these determinations, the obligation under 5D centers not on reporting, but on encouraging the colleague to seek assistance, while the obligation under 5E does focus on reporting. But note that 5E discusses reporting when a colleague is unable to perform; whereas, 5D discusses encouraging colleagues to seek assistance when the impairment may adversely affect their professional responsibilities. So, 5D discusses something that may be affecting performance, while 5E addresses a situation in which someone clearly is unable to perform. The 2 situations are distinct. In addition, it is important to note that 5E does not mandate to whom the physical therapist reports; it provides discretion to determine the appropriate authority.

The EJC Opinion titled: Topic: Preserving Confidences; Physical Therapist's Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

Professional Competence

Principle 6A states as follows:

6A. Physical therapists shall achieve and maintain professional competence.

Interpretation: 6A requires the physical therapist to maintain professional competence within his or her scope of practice throughout their career. Maintaining competence is an ongoing process of self-assessment, identification of strengths and weaknesses, acquisition of knowledge and skills based on that assessment, and reflection on and reassessment of performance, knowledge, and skills. Numerous factors including practice setting, types of patients and clients, personal interests, and the addition of new evidence to practice will influence the depth and breadth of professional competence in a given area of practice. Additional resources on continuing competence are available on the APTA website.

Professional Growth

Principle 6D states as follows:

6D. Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.

Interpretation: 6D elaborates on the physical therapist's obligations to foster an environment conducive to professional growth, even when not supported by the organization. The essential idea is that this is the physical therapist's responsibility, whether or not the employer provides support.

Charges and Coding

Principle 7E states as follows:

> 7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided.
>
> Interpretation: Principle 7E provides that the physical therapist must make sure that the process of documentation and coding accurately captures the charges for services performed. Additional resources on Documentation and Coding and Billing are available on the APTA website.

Pro Bono Services

Principle 8A states as follows:

> 8A. Physical therapists shall provide pro bono physical therapist services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.
>
> Interpretation: The key word in Principle 8A is "or." If a physical therapist is unable to provide pro bono services, then he or she can fulfill ethical obligations by supporting organizations that meet the health needs of people who are economically disadvantaged, uninsured, or underinsured. In addition, physical therapists may review the House of Delegates guidelines titled Guidelines: Pro Bono Physical Therapist Services and Organizational Support. Additional resources on pro bono physical therapist services are available on the APTA website.
>
> 8A also addresses supporting organizations to meet health needs. The principle does not specify the type of support that is required. Physical therapists may express support through volunteerism, financial contributions, advocacy, education, or simply promoting their work in conversations with colleagues.

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American Physical Therapy Association
October 1981
Last Amended March 2019

Standards of Ethical Conduct for the Physical Therapist Assistant **HOD S06-19-47-68** [Amended HOD S06-09-20-18; HOD S06-00-13-24; HOD 06-91-06-07; Initial HOD 06- 82-04-08] [Standard]

Preamble

The Standards of Ethical Conduct for the Physical Therapist Assistant (Standards of Ethical Conduct) delineate the ethical obligations of all physical therapist assistants as determined by the House of Delegates of the American Physical Therapy Association (APTA). The Standards of Ethical Conduct provide a foundation for conduct to which all physical therapist assistants shall adhere. Fundamental to the Standards of Ethical Conduct is the special obligation of physical therapist assistants to enable patients and clients to achieve greater independence, health and wellness, and enhanced quality of life.

No document that delineates ethical standards can address every situation. Physical therapist assistants are encouraged to seek additional advice or consultation in instances where the guidance of the Standards of Ethical Conduct may not be definitive.

Standards

Standard #1: Physical therapist assistants shall respect the inherent dignity, and rights, of all individuals.

1A. Physical therapist assistants shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

1B. Physical therapist assistants shall recognize their personal biases and shall not discriminate against others in the provision of physical therapist services.

Standard #2: Physical therapist assistants shall be trustworthy and compassionate in addressing the rights and needs of patients and clients.

2A. Physical therapist assistants shall act in the best interests of patients and clients over the interests of the physical therapist assistant.

2B. Physical therapist assistants shall provide physical therapist interventions with compassionate and caring behaviors that incorporate the individual and cultural differences of patients and clients.

2C. Physical therapist assistants shall provide patients and clients with information regarding the interventions they provide.

2D. Physical therapist assistants shall protect confidential patient and client information and, in collaboration with the physical therapist, may disclose confidential information to appropriate authorities only when allowed or as required by law.

Standard #3: Physical therapist assistants shall make sound decisions in collaboration with the physical therapist and within the boundaries established by laws and regulations.

3A. Physical therapist assistants shall make objective decisions in the patient's or client's best interest in all practice settings.

3B. Physical therapist assistants shall be guided by information about best practice regarding physical therapist interventions.

3C. Physical therapist assistants shall make decisions based upon their level of competence and consistent with patient and client values.

3D. Physical therapist assistants shall not engage in conflicts of interest that interfere with making sound decisions.
3E. Physical therapist assistants shall provide physical therapist services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when patient or client status requires modifications to the established plan of care.

Standard #4: Physical therapist assistants shall demonstrate integrity in their relationships with patients and clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.

4A. Physical therapist assistants shall provide truthful, accurate, and relevant information and shall not make misleading representations.
4B. Physical therapist assistants shall not exploit persons over whom they have supervisory, evaluative or other authority (e.g, patients and clients, students, supervisees, research participants, or employees).
4C. Physical therapist assistants shall not engage in any sexual relationship with any of their patients and clients, supervisees, or students.
4D. Physical therapist assistants shall not harass anyone verbally, physically, emotionally, or sexually.
4E. Physical therapist assistants shall discourage misconduct by physical therapists, physical therapist assistants, and other health care professionals and, when appropriate, report illegal or unethical acts, including verbal, physical, emotional, or sexual harassment, to an appropriate authority with jurisdiction over the conduct.
4F. Physical therapist assistants shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.

Standard #5: Physical therapist assistants shall fulfill their legal and ethical obligations.

5A. Physical therapist assistants shall comply with applicable local, state, and federal laws and regulations.
5B. Physical therapist assistants shall support the supervisory role of the physical therapist to ensure quality care and promote patient and client safety.
5C. Physical therapist assistants involved in research shall abide by accepted standards governing protection of research participants.
5D. Physical therapist assistants shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.
5E. Physical therapist assistants who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

Standard #6: Physical therapist assistants shall enhance their competence through the lifelong acquisition and refinement of knowledge, skills, and abilities.

6A. Physical therapist assistants shall achieve and maintain clinical competence.
6B. Physical therapist assistants shall engage in lifelong learning consistent with changes in their roles and responsibilities and advances in the practice of physical therapy.
6C. Physical therapist assistants shall support practice environments that support career development and lifelong learning.

Standard #7: Physical therapist assistants shall support organizational behaviors and business practices that benefit patients and clients and society.

7A. Physical therapist assistants shall promote work environments that support ethical and accountable decision-making.
7B. Physical therapist assistants shall not accept gifts or other considerations that influence or give an appearance of influencing their decisions.
7C. Physical therapist assistants shall fully disclose any financial interest they have in products or services that they recommend to patients and clients.
7D. Physical therapist assistants shall ensure that documentation for their interventions accurately reflects the nature and extent of the services provided.
7E. Physical therapist assistants shall refrain from employment arrangements, or other arrangements, that prevent physical therapist assistants from fulfilling ethical obligations to patients and clients

Standard #8: Physical therapist assistants shall participate in efforts to meet the health needs of people locally, nationally, or globally.

8A. Physical therapist assistants shall support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.
8B. Physical therapist assistants shall advocate for people with impairments, activity limitations, participation restrictions, and disabilities in order to promote their participation in community and society.
8C. Physical therapist assistants shall be responsible stewards of health care resources by collaborating with physical therapists in order to avoid overutilization or underutilization of physical therapist services.
8D. Physical therapist assistants shall educate members of the public about the benefits of physical therapy.

Effective June 2019
For more information, go to www.apta.org/ethics.

APTA Guide for Conduct of the Physical Therapist Assistant

Purpose

The APTA Guide for Conduct of the Physical Therapist Assistant (Guide) is intended to serve physical therapist assistants in interpreting the Standards of Ethical Conduct for the Physical Therapist Assistant (Standards of Ethical Conduct) of the American Physical Therapy Association (APTA). The APTA House of Delegates in June of 2009 adopted the revised Standards of Ethical Conduct, which became effective July 1, 2010.

The Guide provides a framework by which physical therapist assistants may determine the propriety of their conduct. It also is intended to guide the development of physical therapist assistant students. The Standards of Ethical Conduct and the Guide apply to all physical therapist assistants. These guidelines are subject to change as the dynamics of the profession change and as new patterns of health care delivery are developed and accepted by the professional community and the public.

Interpreting the Standards of Ethical Conduct

The interpretations expressed in this Guide reflect the opinions, decisions, and advice of the Ethics and Judicial Committee (EJC). The interpretations are set forth according to topic. These interpretations are intended to assist a physical therapist assistant in applying general ethical standards to specific situations. They address some but not all topics addressed in the Standards of Ethical Conduct and should not be considered inclusive of all situations that could evolve.

This Guide is subject to change, and the Ethics and Judicial Committee will monitor and revise the Guide to address additional topics and standards when and as needed.

Preamble to the Standards of Ethical Conduct

The Preamble states as follows:

The Standards of Ethical Conduct for the Physical Therapist Assistant (Standards of Ethical Conduct) delineate the ethical obligations of all physical therapist assistants as determined by the House of Delegates of the American Physical Therapy Association (APTA). The Standards of Ethical Conduct provide a foundation for conduct to which all physical therapist assistants shall adhere. Fundamental to the Standards of Ethical Conduct is the special obligation of physical therapist assistants to enable patients/clients to achieve greater independence, health and wellness, and enhanced quality of life. No document that delineates ethical standards can address every situation. Physical therapist assistants are encouraged to seek advice or consultation in instances where the guidance of the Standards of Ethical Conduct may not be definitive.

Interpretation: Upon the Standards of Ethical Conduct for the Physical Therapist Assistant being amended effective July 1, 2010, all the lettered standards contain the word “shall” and are mandatory ethical obligations. The language contained in the Standards of Ethical Conduct is intended to better explain and further clarify existing ethical obligations. These ethical obligations predate the revised Standards of Ethical Conduct. Although various words have changed, many of the obligations are the same. Consequently, the addition of the word “shall” serves to reinforce and clarify existing ethical obligations. A significant reason that the Standards of Ethical Conduct were revised was to provide

physical therapist assistants with a document that was clear enough to be read on its own without the need to seek extensive additional interpretation.

The Preamble states that "[n]o document that delineates ethical standards can address every situation." The Preamble also states that physical therapist assistants "are encouraged to seek additional advice or consultation in instances where the guidance of the Standards of Ethical Conduct may not be definitive." Potential sources for advice or counsel include third parties and the myriad resources available on the APTA website. Inherent in a physical therapist assistant's ethical decision-making process is the examination of his or her unique set of facts relative to the Standards of Ethical Conduct.

Topics

Respect

Standard 1A states as follows:

> 1A. Physical therapist assistants shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

Interpretation: Standard 1A addresses the display of respect toward others. Unfortunately, there is no universal consensus about what respect looks like in every situation. For example, direct eye contact is viewed as respectful and courteous in some cultures and inappropriate in others. It is up to the individual to assess the appropriateness of behavior in various situations.

Altruism

Standard 2A states as follows:

> 2A. Physical therapist assistants shall act in the best interests of patients/clients over the interests of the physical therapist assistant.

Interpretation: Standard 2A addresses acting in the best interest of patients and clients over the interests of the physical therapist assistant. Often this is done without thought, but, sometimes, especially at the end of the day when the clinician is fatigued and ready to go home, it is a conscious decision. For example, the physical therapist assistant may need to make a decision between leaving on time and staying at work longer to see a patient who was 15 minutes late for an appointment.

Sound Decisions

Standard 3C states as follows:

> 3C. Physical therapist assistants shall make decisions based upon their level of competence and consistent with patient/client values.

Interpretation: To fulfill 3C, the physical therapist assistant must be knowledgeable about his or her legal scope of work as well as level of competence. As a physical therapist assistant gains experience and additional knowledge, there may be areas of physical therapy interventions in which he or she displays advanced skills. At the same time, other previously gained knowledge and skill may be lost due to lack of

use. To make sound decisions, the physical therapist assistant must be able to self-reflect on his or her current level of competence.

Supervision

Standard 3E states as follows:

> 3E. Physical therapist assistants shall provide physical therapy services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when patient/client status requires modifications to the established plan of care.

Interpretation: Standard 3E goes beyond simply stating that the physical therapist assistant operates under the supervision of the physical therapist. Although a physical therapist retains responsibility for the patient or client throughout the episode of care, this standard requires the physical therapist assistant to take action by communicating with the supervising physical therapist when changes in the individual's status indicate that modifications to the plan of care may be needed. Further information on supervision via APTA policies and resources is available on the APTA website.

Integrity in Relationships

Standard 4 states as follows:

> 4. Physical therapist assistants shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, other health care providers, employers, payers, and the public.

Interpretation: Standard 4 addresses the need for integrity in relationships. This is not limited to relationships with patients and clients but includes everyone physical therapist assistants come into contact with in the normal provision of physical therapist services. For example, demonstrating integrity could encompass working collaboratively with the health care team and taking responsibility for one's role as a member of that team.

Reporting

Standard 4C states as follows:

> 4C. Physical therapist assistants shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.

Interpretation: Physical therapist assistants shall seek to discourage misconduct by health care professionals. Discouraging misconduct can be accomplished through a number of mechanisms. The following is not an exhaustive list:

- Do not engage in misconduct; instead, set a good example for health care professionals and others working in their immediate environment.
- Encourage or recommend to the appropriate individuals that health care and other professionals, such as legal counsel, conduct regular (such as annual) training that addresses federal and state law requirements, such as billing, best practices, harassment, and security and privacy; as such training can educate health care professionals on what to do and not to do.
- Encourage or recommend to the appropriate individuals other types of training that are

not law based, such as bystander training.
- Assist in creating a culture that is positive and civil to all.
- If in a management position, consider how promotion and hiring decisions can impact the organization.
- Access professional association resources when considering best practices.
- Revisit policies and procedures each year to remain current.

Many other mechanisms may exist to discourage misconduct. The physical therapist assistant should be creative, open-minded, fair, and impartial in considering how to best meet this ethical obligation. Doing so can actively foster an environment in which misconduct does not occur. The main focus when thinking about misconduct is creating an action plan on prevention. Consider that reporting may never make the alleged victim whole or undo the misconduct.

If misconduct has not been prevented, then reporting issues must be considered. This ethical obligation states that the physical therapist assistant reports to the "relevant authority, when appropriate." Before examining the meaning of these words it is important to note that reporting intersects with corporate policies and legal obligations. It is beyond the scope of this interpretation to provide legal advice regarding laws and policies; however, an analysis of reporting cannot end with understanding one's ethical obligations. One may need to seek advice of legal counsel who will take into consideration laws and policies and seek to discover the facts and circumstances.

With respect to ethical obligations, the term "when appropriate" is a fact-based decision and will be impacted by requirements of the law. If a law requires the physical therapist assistant to take an action, then, of course, it is appropriate to do so. If there is no legal requirement and no corporate policy, then the physical therapist assistant must consider what is appropriate given the facts and situation. It may not be appropriate if the physical therapist does not know what occurred, or because there is no legal requirement to act and the physical therapist assistant does not want to assume legal responsibility, or because the matter is being resolved internally. There are many different reasons that something may or may not be appropriate.

If the physical therapist assistant has determined that it is appropriate to report, the ethical obligation requires him or her to consider what entity or person is the "relevant authority." Relevant authority can be a supervisor, human resources, an attorney, the Equal Employment Opportunities Commission, the licensing board, the Better Business Bureau, Office of the Insurance Commissioner, the Medicare hotline, the Office of the Inspector General hotline, the US Department of Health and Human Services, an institution using their internal grievance procedures, the Office of Civil Rights, or another federal, state, city, or local agency, or a state or federal court, among others.

Once the physical therapist assistant has decided to report, he or she must be mindful that reporting does not end his or her involvement, which can include office, regulatory, and/or legal proceedings. In this context, the physical therapist assistant may be asked to be a witness, to testify, or to provide written information.

Sexual Harassment

Standard 4F states as follows:

> 4F. Physical therapist assistants shall not harass anyone verbally, physically, emotionally, or sexually.

Interpretation: As noted in the House of Delegates policy titled "Sexual Harassment," "[m]embers of the association have an obligation to comply with applicable legal prohibitions against sexual harassment…." This statement is in line with Standard 4F that prohibits physical therapist assistants from harassing anyone verbally, physically, emotionally, or sexually. While the standard is clear, it is important for APTA to restate this point, namely that physical therapist assistants shall not harass anyone, period. The association has zero tolerance for any form of harassment, specifically including sexual harassment.

Exploitation

Standard 4E states as follows:

> 4E. Physical therapist assistants shall not engage in any sexual relationship with any of their patients/clients, supervisees, or students.

Interpretation: The statement is clear—sexual relationships with their patients or clients, supervisees, or students are prohibited. This component of Standard 4 is consistent with Standard 4B, which states:

> 4B. Physical therapist assistants shall not exploit persons over whom they have supervisory, evaluative, or other authority (eg, patients and clients, students, supervisees, research participants, or employees).
>
> Consider this excerpt from the EJC Opinion titled Topic: Sexual Relationships With Patients or Former Patients (modified for physical therapist assistants):
>
> A physical therapist [assistant] stands in a relationship of trust to each patient and has an ethical obligation to act in the patient's best interest and to avoid any exploitation or abuse of the patient. Thus, if a physical therapist [assistant] has natural feelings of attraction toward a patient, he or she must sublimate those feelings in order to avoid sexual exploitation of the patient.
>
> One's ethical decision making process should focus on whether the patient or client, supervisee, or student is being exploited. In this context, questions have been asked about whether one can have a sexual relationship once the patient or client relationship ends. To this question, the EJC has opined as follows:
>
> The Committee does not believe it feasible to establish any bright-line rule for when, if ever, initiation of a romantic/sexual relationship with a former patient would be ethically permissible.
>
> The Committee imagines that in some cases a romantic/sexual relationship would not offend ... if initiated with a former patient soon after the termination of treatment, while in others such a relationship might never be appropriate.

Colleague Impairment

Standard 5D and 5E state as follows:

> 5D. Physical therapist assistants shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

> 5E. Physical therapist assistants who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

Interpretation: The central tenet of Standard 5D and 5E is that inaction is not an option for a physical therapist assistant when faced with the circumstances described. Standard 5D states that a physical therapist assistant shall encourage colleagues to seek assistance or counsel while Standard 5E addresses reporting information to the appropriate authority.

5D and 5E both require a factual determination on the physical therapist assistant's part. This may be challenging in the sense that the physical therapist assistant might not know or easily be able to determine whether someone in fact has a physical, psychological, or substance-related impairment. In addition, it might be difficult to determine whether such impairment may be adversely affecting someone's work responsibilities.

Moreover, once the physical therapist assistant does make these determinations, the obligation under 5D centers not on reporting, but on encouraging the colleague to seek assistance, while the obligation under 5E does focus on reporting. But note that 5E discusses reporting when a colleague is unable to perform; whereas, 5D discusses encouraging colleagues to seek assistance when the impairment may adversely affect their professional responsibilities. So, 5D discusses something that may be affecting performance, whereas 5E addresses a situation in which someone clearly is unable to perform. The 2 situations are distinct. In addition, it is important to note that 5E does not mandate to whom the physical therapist assistant reports; it provides discretion to determine the appropriate authority.

The EJC Opinion titled Topic: Preserving Confidences; Physical Therapist's Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

Clinical Competence

Standard 6A states as follows:

> 6A. Physical therapist assistants shall achieve and maintain clinical competence.

Interpretation: 6A should cause physical therapist assistants to reflect on their current level of clinical competence, to identify and address gaps in clinical competence, and to commit to the maintenance of clinical competence throughout their career. The supervising physical therapist can be a valuable partner in identifying areas of knowledge and skill that the physical therapist assistant needs for clinical competence and to meet the needs of the individual physical therapist, which may vary according to areas of interest and expertise. Further, the physical therapist assistant may request that the physical therapist serve as a mentor to assist him or her in acquiring the needed knowledge and skills. Additional resources on Continuing Competence are available on the APTA website.

Lifelong Learning

Standard 6C states as follows:

> 6C. Physical therapist assistants shall support practice environments that support career development and lifelong learning.

Interpretation: 6C points out the physical therapist assistant's obligation to support an environment conducive to career development and learning. The essential idea here is that the physical therapist assistant encourages and contributes to his or her career development and lifelong learning, whether or not the employer provides support.

Organizational and Business Practices

Standard 7 states as follows:

> 7. Physical therapist assistants shall support organizational behaviors and business practices that benefit patients/clients and society.

Interpretation: Standard 7 reflects a shift in the Standards of Ethical Conduct. One criticism of the former version was that it addressed primarily face-to-face clinical practice settings. Accordingly, Standard 7 addresses ethical obligations in organizational and business practices on both patient and client and societal levels.

Documenting Interventions

Standard 7D states as follows:

> 7D. Physical therapist assistants shall ensure that documentation for their interventions accurately reflects the nature and extent of the services provided.

Interpretation: 7D addresses the need for physical therapist assistants to make sure that they thoroughly and accurately document the interventions they provide to patients and clients and document related data collected from the patient or client. The focus of this Standard is on ensuring documentation of the services rendered, including the nature and extent of such services.

Support - Health Needs

Standard 8A states as follows:

> 8A. Physical therapist assistants shall support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

Interpretation: 8A addresses the issue of support for those least likely to be able to afford physical therapist services. The standard does not specify the type of support that is required. Physical therapist assistants may express support through volunteerism, financial contributions, advocacy, education, or simply promoting their work in conversations with colleagues. When providing such services, including *pro bono* services, physical therapist assistants must comply with applicable laws, and as such work under the direction and supervision of a physical therapist. Additional resources on *pro bono* services are available on the APTA website.

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LOMA LINDA UNIVERSITY SCHOOL OF ALLIED HEALTH PROFESSIONS
Department of Physical Therapy PTA & DPT Programs
Professional Appearance Standards

Students in the program are expected to present an appearance consistent with the highest professional standards in healthcare and with the mission and philosophy of Loma Linda University. These standards apply during scheduled school hours in classrooms, laboratories, chapel, and in all facilities used for physical therapy education purposes, including clinics and off-campus assignments. Clinical sites affiliating with Loma Linda University may prescribe additional codes of dress for students in training. Alternate dress codes during laboratory sessions will be outlined by the course instructors.

In essence, a professional appearance is defined as modest, neat, clean, and conservative in style.

- Men
  - Dress slacks or long pants such as chinos or khakis
  - Shirts: neatly pressed and with collars
  - Scrub sets may be worn as an alternative (see below)
- Women
  - Dresses/skirts must approximate or fall below the knees
  - Dress slacks or long pants such as chinos or khakis
  - Blouses/tops: modesty required; no exposed mid-riffs, low-cut necklines and skin-tight clothing
  - Scrub sets may be worn as an alternative (see below)
- Scrub sets for men or women
  - Scrubs must be neat, clean and in a solid color
  - Scrub top and pants must be the same color
  - A black polo shirt with departmental logo may be paired with scrub pants
  - A plain T-shirt (long or short-sleeved) with a crew or V-neck may be worn under the scrub top and must be tucked in at the waist.
- Shoes: clean, good condition; no flip-flops

- The following items are considered inappropriate for professional attire:
  - T-shirts worn as outer garments
  - Visible undergarments
  - Denim clothing of any color
  - Shorts
  - Halter tops, tank tops, midriffs, or “spaghetti” straps
  - Sweat pants, leggings (aka: yoga pants)
  - Hats, caps, beanies, or hoods of sweatshirts worn indoors
- Extreme hairstyles are not acceptable for men or women:
  - Men: Hair must be clean, neat, and not fall below the collar. Mustaches and beards must be closely trimmed. Women: Hair must be clean, neat; long hair may need to be tied back.

- Jewelry, if worn, must be conservative. Rings, if worn, should be low-profile and limited to one finger per hand. Ear ornaments, if worn by women, are limited to simple studs in the earlobe, one per ear, and should not drop below the bottom of the earlobe. Men may not wear ear ornaments. Rings or ornaments in other anatomical sites are not acceptable.

- Nails must be closely trimmed. Nail polish, if worn, should be a subdued tone.

- Excessive makeup and strong fragrances are not appropriate.

- Any display of words, pictures, and symbols must be consistent with Christian principles and be sensitive to others’ views. If found offensive, tattoos must remain covered while in program, at the discretion of faculty.

I have read the Professional Appearance Standards and I agree to observe them.
Student Signature _____Date _____ ***Revised 2018-12-12***

Procedure for Evaluating An Individual's Fitness For Duty And Accommodating An Individual's Clinical Assignment.

Evaluation of an individual's fitness for duty will be performed by the clinical coordinator in the following areas:

A. Competence
    1. Medical condition resulting in incompetence
    2. Emotional instability to perform assigned tasks
B. Ability to perform routine duties
    1. Inability to perform regular duties, assuming "reasonable accommodations" have been offered for the disability
    2. Susceptible to varicella zoster virus, rubella or measles
C. Compliance with established guidelines and procedures
    1. Refusal to follow guidelines
    2. Unable to comprehend guidelines

The clinical coordinator makes accommodations for a student from a clinical experience perspective on a case-by-case basis. Decisions for exemption for more than one clinical session will be made in consultation with the student's physician and appropriate University faculty/administrators, including the chairperson of the University Communicable Disease and AIDS Committee. The following conditions require consideration when assigning a student to clients with communicable disease.

A. Confirmed pregnancy
    1. The risk of transmission of HIV infection to pregnant health care workers is not known to be greater than the risk to those not pregnant.
    2. The risk of transmission of other pathogens such as cytomegalovirus from clients with AIDS to pregnant health care workers is unknown but is thought to be low to nonexistent.
    3. If, however, due to personal concerns related to protection of the fetus, pregnant students, in consultation with the clinical coordinator, may be excluded by caring for clients infected with known communicable diseases or blood borne pathogens.
B. Incompetent Immunological Systems
    Students with diagnosed immunological deficiencies are at an increased risk for developing opportunistic infections. In consultation with the clinical coordinator, these students may request exclusion from caring for clients with known communicable diseases or blood-borne pathogens.
C. Infections
    Any student with a communicable infectious process could further compromise an already incompetent immunological system, such as a client who is neutrophic from chemotherapy, an AIDS client, or other immune-compromised client; thus, a student may, in consultation with the clinical coordinator, request a change in assignment.

From the School of Allied Health Professions Policy Handbook, p. 5 and 6.

LOMA LINDA UNIVERSITY

Department of Risk Management

Loma Linda, California 92350
(909) 558-4386
FAX: (909) 558-4775

To Whom It May Concern:

RE: Student Health Plan & Risk Management Programs

The purpose of this letter is to outline and clarify the protection afforded to students and/or employees under the various insurance and risk management programs in effect at Loma Linda University. All coverage descriptions are subject to the limits of liability, exclusions, conditions, and other terms of the actual insurance or self-insurance program in effect.

Professional Liability – The primary professional liability exposures at Loma Linda University are funded through a self-insurance trust program established at Bank of America, Chicago, Illinois. Excess coverage is provided through University Insurance Company of Vermont, policy number XS-1014. Professional liability coverage applies to both employees and students. Employees are only covered while functioning within the course and scope of their duties as employees of Loma Linda University. Students are covered while enrolled in a formal training program offered by Loma Linda University, but only for such student's legal liability resulting from the performance of or failure to perform duties relating to the training program.

Student Health Plan – All full time students at Loma Linda University enrolled in any regular educational program are covered by the Student Health Plan. This program provides accident and sickness benefits while enrolled. Coverage under the Student Health Plan also applies to any student while participating in clinical rotations sponsored by Loma Linda University.

Workers' Compensation – In accordance with the California State Labor Code, Loma Linda University is self-insured for the Workers' Compensation exposures of its *employees*. Loma Linda has been granted a Certificate of Consent to Self-Insure, #1095, by the Department of Industrial Relations of the State of California, and provides statutory workers' compensation benefits to all *employees* who sustain job-related injuries or illnesses. Benefits under this program include all necessary medical care, temporary disability benefits, and long-term benefits in accordance with the State Labor Code. Students are generally not considered employees for purposes of workers' compensation coverage.

Sincerely,

Raul E. Castillo
Risk Manager

(updated 06/06/05)

Jenni Rae Rubio, PTA, B.S.
Director of Clinical Education, PTA Program
1914 Nichol Hall, SAHP, LLU
Loma Linda CA, 92350
Tele: 909 558-4632 ext. 47208
Email: jrubio@llu.edu

School of Allied Health Professions, Loma Linda University
Physical Therapy Assistant Program

Memo

TO: PTA Student

FROM: Jenni Rae Rubio

CC:

Date: 07/2023

Re: Risk Management and Student Health

Contact for Risk Management is (909) 558-1000 ext. 58113

If you should need medical attention while away from campus on a clinical rotation contact the representative, James Mendez, at that number for insurance approval. Provide him with receipts for services rendered.

Student Health contact is (909) 558-1000 ext. 88770

The DCE must also be notified of all illnesses which necessitate absences from the clinic or visits to the doctor.

Loma Linda University policy on Sexual Harassment is found in the Student Handbook –online-

(see attached document)

Sexual Harassment

GENERAL RULE:
Loma Linda University is committed to providing a learning and work environment that is free of discrimination and harassment of any form. In keeping with this commitment, Loma Linda University maintains a strict policy prohibiting all forms of harassment including sexual harassment and harassment based on race, color, national origin, medical condition, physical handicap or age. Also prohibited is retaliation of any kind against individuals who file valid complaints or who assist in a University investigation.

Sexual harassment is especially serious when it threatens relationships between teacher and student, supervisor and subordinate, or clinician and patient. In such situations, sexual harassment exploits unfairly the power inherent in a faculty member's, supervisor's or clinician's position. Through grades, wage increases, recommendations for graduate study, promotion, clinical priority, and the like, a person in a position of power can have a decisive influence on the future of the student, faculty member, employee, or patient. The University will not tolerate behavior between or among members of the University community which creates an unacceptable educational, working, or clinical environment.

Sexual harassment and illegal discrimination are reprehensible and will not be tolerated by Loma Linda University. These actions subvert the mission of the University and threaten the careers, educational experience, and well being of students, employees and patients. Any individual found to have acted in violation of this policy should be subject to appropriate disciplinary action including warnings, reprimands, suspensions and/or dismissal.

DEFINITION OF SEXUAL HARASSMENT AND PROHIBITED ACTS

Sexual harassment is unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature, when submission to or rejection of this conduct explicitly or implicitly affects a person's employment or education, unreasonably interferes with a person's work or educational performance, or creates an intimidating, hostile or offensive working or learning environment.

Sexual harassment may include incidents between any member of the University community, including faculty and other academic appointees, staff, deans, students and non-students or non-employee participants in University programs such as vendors, contractors, visitors and patients.

For purposes of this policy, sexual harassment includes, but is not limited to, making unwanted sexual advances and requests for sexual favors where:

1. Submission to such conduct is made an explicit or implicit term or condition of educational evaluation, opportunity or advancement;

2. Submission to or rejection of such conduct by an individual is made as the basis for student decisions affecting such individuals; or

3. Such conduct has the purpose or effect of substantially interfering with an individual's educational performance or of creating an intimidating, hostile or offensive educational environment.

Specific examples of the verbal or physical conduct prohibited by this policy include, but are not limited to:

1. Physical assault.

2. Inappropriate or unwanted touching.

3. Direct or implied threats that submission to sexual advances will be a condition of educational evaluation, opportunity or advancement.

4. Direct or subtle propositions of a sexual nature.

5. Dating, requesting dates, or entering into a romantic relationship between a student and an employee or faculty wherein the employee or faculty is in a position of power or is able to exert influence over the student's educational experience.

6. A pattern of conduct that would discomfort and/or humiliate another individual including, but not limited to:

    a. Unnecessary touching,

    b. Remarks of a sexual nature about a person's clothing or body,

    c. Remarks about sexual activity or speculations about previous sexual experiences,

    d. Visual conduct including leering, sexual gestures or the display of sexually suggestive objects, pictures, language cartoons or jokes.

7. Use of electronic means, including the Internet and E-mail system, to transmit, communicate, or receive sexually suggestive, pornographic or sexually explicit pictures, messages or materials.

Individuals who engage in isolated conduct of the kind described above or who exhibit a pattern of engaging in such conduct but fail to realize that their actions cause discomfort demonstrate insensitivity that necessitates remedial measures. The University or school will direct that those engaged in such conduct, **at a minimum,** undertake an educational program designed to help them understand the harm caused. Nonetheless, the University retains its right to dismiss any individual even where the incident is isolated.

Harassment that is not sexual in nature but is based on gender or race is also prohibited if it is sufficiently severe to deny or limit a person's ability to participate in or benefit from the University educational programs, employment or services.

DISSEMINATION OF POLICY

This policy shall be disseminated to the University community through publications, websites, student orientations, and other appropriate channels of communication. It is the responsibility of the Office of the Vice President for Student Services to work with the schools to ensure that the policy is disseminated and implemented. The Office of the Provost is charged with sending an annual letter to all faculty and staff to remind them of the contents of the sexual harassment policy, including the provisions added to it by this policy.

REPORTS OF SEXUAL HARASSMENT

Any student that believes that they have been harassed or that they have been operating under a hostile environment may report such conduct to the University or school administration.
The student may meet directly with the individual involved in the complaint and come to a mutually agreed upon resolution. The student may choose to take someone with him/her, such as a faculty member, department chair, unit manager, clinical instructor, chief resident, or other individual.
If the student is uncomfortable with meeting the individual involved he/she is encouraged to follow the procedure below. Students are reminded that reporting inappropriate conduct is a personal and professional responsibility.

The procedure is to:

1. Report the incident(s) to the dean's office in the school in which the student has their primary enrollment or the Office of the University Vice President for Student Services.

2. In the event a faculty member is the accused, it will be the responsibility of the school's Dean's office to investigate, document and take immediate appropriate corrective measures/protective action that is reasonably calculated to end any harassment, eliminate a hostile environment, and prevent harassment from occurring again.

3. In determining the actions to be taken, consideration will be given to frequency and/or severity of the conduct as well as the position held by the accused. A primary objective will be to protect the student from any adverse consequences for having reported the incident.

CONFIDENTIALITY

The University shall protect the privacy of individuals involved in a report of sexual harassment to the extent required by law and University policy. Anyone requesting confidentiality shall be informed that complete and total confidentiality may not be possible and that some level of disclosure may be necessary to ensure a complete and fair investigation. Disclosure may be made only on a need to know basis.

DUTY TO INVESTIGATE AND TAKE CORRECTIVE ACTION

Once the University is on notice of possible harassment, it is responsible for taking **immediate** and appropriate steps to investigate or otherwise take steps that are reasonably calculated to end any harassment or hostile environment **whether or not** a complaint has been initiated by anyone or corrective action is requested by the complainant.

The goal is to have a quick resolution with the intention not to exceed 45 days. The parties may be informed of the outcome of an investigation within thirty days of its completion as appropriate.

The parties will have a right to provide witnesses, documentation or other evidence appropriate to substantiate their claim or defenses.

The parties will be notified of the outcome of the complaint, as appropriate.

RETALIATION PROHIBITED

All reasonable action will be taken to assure no retaliation against the complainant, witnesses or anyone cooperating with the investigation for their cooperation.

DISCIPLINARY ACTION

Any member of the University community who is found to have engaged in sexual harassment is subject to disciplinary action up to and including dismissal.

Any manager, supervisors, or designated employee responsible for reporting or responding to sexual harassment that knew about the harassment and took no action to stop it or failed to report the prohibited harassment also may be subject to disciplinary action.

Violations of this policy by faculty members will be referred to the dean of the school where the faculty is employed and will be governed by the procedures for discipline set forth in the Faculty Handbook.

Violations of this policy by staff members in academic units of the University will be taken by the dean of the school employing the staff member and will be governed by the procedures for discipline set forth in the Staff Handbook.

Violations of this policy by an employee of a nonacademic unit of the University will be taken by the administrator who makes decisions about the employment status of the accused and will be governed by the procedures for discipline set forth in the Staff Handbook.

Violations of this policy by students, including graduate assistants, will be governed by the disciplinary procedures of the Student Handbook.

INTENTIONALLY FALSE REPORTS

Individuals who make reports that are later found to have been intentionally false or made maliciously without regard for truth may be subject to disciplinary action including termination.

This provision does not apply to reports made in good faith.

Sexual Standards Policy

Faculty, staff, administration, trustees, and students of the University are expected, in their teaching, influence, and example, to uphold Christian sexual standards as held by the Seventh-day Adventist Church. We believe that God's ideal for sexuality is achieved when sexual expression is limited to a man and woman who are husband and wife committed in lifelong marriage. All expressions of premarital and extramarital friendship are to be chaste, and behaviors which would suggest otherwise are to be avoided. All forms of sexual expression and conduct between heterosexuals outside of marriage, or between homosexuals, are contrary to the ideals of the University and will result in disciplinary action. Further, all forms of promiscuity, sexual abuse, and exploitation are contrary to the ideals of the University and will result in disciplinary action. Loma Linda University honors an ideal of sexual purity that transcends mere legal enforcements.

Romantic Relationships and Dating

The University wishes to promote the ethical and efficient operation of its academic programs and business. In this setting, the University wishes to avoid misunderstandings, complaints of favoritism, other problems of supervision, security, and morale, and possible claims of sexual harassment among its students, staff, and faculty. For these reasons:

1. A faculty member is prohibited from pursuing a romantic relationship with or dating a student who is registered in any course or program or who is involved in any other academic activity in which the faculty

member is responsible as an instructor, coordinator, mentor, or committee member, for the duration of such course, program, or other academic activity.

2. A staff member is prohibited from pursuing a romantic relationship with or dating a student who is registered in any course or program or who is involved in any other academic activity in which the staff member participates in any direct supporting role, for the duration of such course, program, or other academic activity.

3. A University administrator or supervisor is prohibited from pursuing a romantic relationship with or dating any employee of the University whom he/she supervises for the duration of the supervision.

For the purposes of this policy, "romantic relationship" is defined as a mutually desired courting activity between two individuals. "Dating" is defined as a romantic social engagement arranged by personal invitation between the two individuals involved or arranged by a third party.

Faculty, staff, and administrators who violate these guidelines will be subject to discipline, up to and including termination of employment and/or loss of faculty appointment. Students who participate in the violation of these guidelines will be subject to discipline, up to and including discontinuance as a student at LLU.

See Seventh-day Adventists Believe, Hagerstown, MD: Review & Herald Publishing Association, 1988:294 and Action from 1987 Annual Council of the General Conference: "Statement of Concerns on Sexual Behavior," Adventist Review, January 14, 1998:21 for a position paper on this understanding. Copies may be obtained from the vice-President or the dean of your school.

Loma Linda University
Department of Physical Therapy
Physical Therapist Program

Identification and Supervision of Physical Therapist Students

The faculty of the DPT Program at Loma Linda University have formalized the policy regarding requirements of supervision and documentation for our students which reflects both legal and ethical mandates. A description of what constitutes legal supervision is excerpted below from the "California Code of Regulations".

16 CCR § 1398.37

§ 1398.37. Identification and Supervision of Physical Therapist Students Defined.

(a) When rendering physical therapy services as part of academic training, a physical therapy student shall only be identified as a "physical therapist student." When rendering physical therapy services, the required identification shall be clearly visible and include his or her name and working title in at least 18-point type.

(b) The "clinical instructor" or the "supervisor" shall be the physical therapist supervising the physical therapist student while practicing physical therapy.

(c) The supervising physical therapist shall provide on-site supervision of the assigned patient care rendered by the physical therapist student.

(d) The physical therapist student shall document each treatment in the patient record, along with his or her signature. The clinical instructor or supervising physical therapist shall countersign with his or her first initial and last name all entries in the patient's record on the same day as patient related tasks were provided by the physical therapist student.

Note: Authority cited: Section 2615, Business and Professions Code. Reference: Section 2633.7, Business and Professions Code.

HISTORY

1. New section filed 4-16-79; effective thirtieth day thereafter (Register 79, No. 16).

2. Amendment filed 6-29-83; effective thirtieth day thereafter (Register 83, No. 27).

3. Amendment of section heading, section and Note filed 12-23-2002; operative 1-22-2003 (Register 2002, No. 52).

4. Change without regulatory effect amending section heading, section and Note filed 9-21-2015 pursuant to section 100, title 1, California Code of Regulations (Register 2015, No. 39).

5. Change without regulatory effect amending Note filed 7-6-2017 pursuant to section 100, title 1, California Code of Regulations (Register 2017, No. 27).

Loma Linda University
Department of Physical Therapy
Physical Therapist Assistant Program

Identification and Supervision of Physical Therapist Assistant Students

The faculty of the Physical Therapist Assistant Program at Loma Linda University have formalized the policy regarding requirements of supervision and documentation for our students which reflects both legal and ethical mandates. A description of what constitutes legal supervision is excerpted below form "California Code of Regulations".

16 CCR § 1398.52

§ 1398.52. Identification and Supervision of Physical Therapist Assistant Students Defined.

(a) A physical therapist assistant student is an unlicensed person rendering physical therapy services as part of academic training pursuant to section 2650.1 of the Code and shall only be identified as a "physical therapist assistant student." When rendering physical therapy services, the required identification shall be clearly visible and include his or her name and working title in at least 18-point type.

(b) The physical therapist assistant student shall be supervised by a physical therapist supervisor. A physical therapist assistant under the supervision of a physical therapist supervisor may perform as a clinical instructor of the physical therapist assistant student when rendering physical therapy services.

(c) A physical therapist supervisor shall provide on-site supervision of the assigned patient care rendered by the physical therapist assistant student.

(d) The physical therapist assistant student shall document each treatment in the patient record, along with his or her signature. The clinical instructor shall countersign with his or her first initial and last name in the patient's record on the same day as patient related tasks were provided by the physical therapist assistant student. The supervising physical therapist shall conduct a weekly case conference and document it in the patient record.

Note: Authority cited: Section 2615, Business and Professions Code. Reference: Section 2633.7, Business and Professions Code.

HISTORY

1. New section filed 12-23-2002; operative 1-22-2003 (Register 2002, No. 52).

2. Change without regulatory effect amending section heading, section and Note filed 9-21-2015 pursuant to section 100, title 1, California Code of Regulations (Register 2015, No. 39).

3. Change without regulatory effect amending Note filed 7-6-2017 pursuant to section 100, title 1, California Code of Regulations (Register 2017, No. 27).

APTA

American Physical Therapy Association

The Science of Healing. The Art of Caring.

DESIGNATION "PT," "PTA," "SPT," AND "SPTA" HOD P06-03-17-14 [Amended HOD 06-99-23-29; HOD 06-78-05-04; HOD 06-85-38-66] [Position]

The American Physical Therapy Association (APTA) supports the use of "PT" as the regulatory designation of a physical therapist. Other letter designations such as "RPT," "LPT," or academic and professional degrees, should not be substituted for the regulatory designation of "PT." "PTA" is the preferred regulatory designation of a physical therapist assistant.

APTA supports the recognition of the regulatory designation of a physical therapist or a physical therapist assistant as taking precedence over other credentials or letter designations. In order to promote consistent communication of the presentation of credentials and letter designations, the Association shall recognize the following preferred order:

1. PT/PTA.
2. Highest earned physical therapy-related degree.
3. Other earned academic degree(s).
4. Specialist certification credentials in alphabetical order (specific to the American Board of Physical Therapy Specialties).
5. Other credentials external to APTA.
6. Other certification or professional honors (eg, FAPTA).

APTA supports the designations "SPT" and "SPTA" for physical therapist students and physical therapist assistant students, respectively, up to the time of graduation. Following graduation and prior to licensure, graduates should be designated in accordance with state law. If state law does not stipulate a specific designation, graduates should be designated in a way that clearly identifies that they are not licensed physical therapists or licensed or regulated physical therapist assistants.

Relationship to Vision 2020: Professionalism; (Practice Department, ext 3176)

[Document updated: 12/14/2009]

Explanation of Reference Numbers:
BOD P00-00-00-00 stands for Board of Directors/month/year/page/vote in the Board of Directors Minutes; the "P" indicates that it is a position (see below). For example, BOD P11-97-06-18 means that this position can be found in the November 1997 Board of Directors minutes on Page 6 and that it was Vote 18.

P: Position | S: Standard | G: Guideline | Y: Policy | R: Procedure

APTA

Last Updated: 10/15/13
Contact: [redacted]

Chart: Supervision of Students Under Medicare

Practice Setting	PT Student Part A	PT Student Part B	PTA Student Part A	PTA Student Part B
PT in Private Practice	N/A	X1	N/A	X1
Certified Rehabilitation Agency	N/A	X1	N/A	X1
Comprehensive Outpatient Rehabilitation Facility	N/A	X1	N/A	X1
Skilled Nursing Facility	Y1	X1	Y2	X1
Hospital	Y3	X1	Y3	X1
Home Health Agency	NAR	X1	NAR	X1
Inpatient Rehabilitation Agency	Y4	N/A	Y4	N/A

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

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.**

Y3: This is not specifically addressed in the regulations, therefore, please defer to state law and standards of professional practice. Additionally, the Part A hospital diagnosis related group (DRG) payment system is similar to that of a skilled nursing facility (SNF) and Medicare has indicated very limited and restrictive requirements for student services in the SNF setting.

Documentation: Please refer to documentation guidance provided under **Y1**

Y4: This is not specifically addressed in the regulations, therefore, please defer to state law and standards of professional practice. Additionally, the inpatient rehabilitation facility payment system is similar to that of a skilled nursing facility (SNF) and Medicare has indicated very limited and restrictive requirements for student services in the SNF setting.

X1: B. Therapy Students

1. General
Only the services of the therapist can be billed and paid under Medicare Part B. However, a student may participate in the delivery of the services if the therapist is directing the service, making the judgment, responsible for the treatment and present in the room guiding the student in service delivery.

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 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).

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.

Essential Functions

Physical Therapist Assistant Program
Department of Physical Therapy
School of Allied Health Professions
Loma Linda University

Based on the philosophy of the Department of Physical Therapy in the School of Allied Health Professions, intent of the professional program is to educate competent generalist physical therapists/physical therapist assistants who can evaluate, manage, and treat the general population of acute and rehabilitation clients in current health care settings. Enrolled students are expected to complete the academic and clinical requirements of the professional DPT/PTA programs.

The following "essential functions" specify those attributes that the faculty consider necessary for completing the professional education enabling each graduate to subsequently enter clinical practice. The Department of Physical Therapy, School of Allied Health Professions will consider for admission any qualified applicant who demonstrates the ability to perform or to learn to perform the "essential functions" specified in this document. Applicants are not required to disclose the nature of any disability(ies) to the physical therapy department; however, any applicant with questions about these "essential functions" is strongly encouraged to discuss the issue with the program director prior to the interview process. If appropriate, and upon the request of the applicant/student, reasonable accommodations may be provided.

Certain chronic or recurrent illnesses and problems that interfere with patient care or safety may be incompatible with physical therapy training or clinical practice. Other illnesses may lead to a high likelihood of student absenteeism and should be carefully considered. Deficiencies in knowledge, judgment, integrity, character, or professional attitude or demeanor which may jeopardize patient care may be grounds for course/rotation failure and possible dismissal from the program.

The purpose of this document is to delineate the cognitive, affective and psychomotor skills deemed essential for completion of this program and to perform as a competent generalist physical therapist/physical therapist assistant.

ESSENTIAL FUNCITIONS REQUIRED TO GRADUATE AS A PHYSICAL THERAPIST ASSISTANT
The student is required to apply essential functions to all patients without bias
See next two pages

LOMA LINDA UNIVERSITY
SCHOOL OF ALLIED HEALTH PROFESSIONS
Department of Physical Therapy
PTA Student - Essential Functions/Consent Form

I, _____, as a student enrolled in the LLU PTA program, hereby voluntarily agree and consent to the following: (Print Name)

☐ _____ (please initial) I understand that while I am enrolled in the Department of Physical Therapy, School of Allied Health Professions, Loma Linda University I will be involved in activities that may increase my risk of injury or illness above those associated with everyday activities of daily living. These activities include:

- Exposure to blood, body fluids and airborne pathogens (Examples: Hepatitis, TB, HIV, needle sticks)
- Musculoskeletal injury - due to performing/receiving physical therapy treatment activities on/from partners in the laboratory setting and on clinical rotations
- Psychological Stress - due to the curriculum load which requires in and out of class commitment to successfully complete the program
- Exposure to hazardous material (Examples: formaldehyde, Betadine, rubbing alcohol)

☐ _____ (please initial) I understand that clinical requirements of facilities used for PTA clinical education may include drug testing and/or background checks and I give permission for such information to be released via mail, email or fax to clinical facility representatives.

☐ _____ (please initial) I understand that to successfully complete the program I must be able to perform the Department of Physical Therapy's "Essential Functions" that are listed below. I understand that if I am an individual with a disability and need reasonable accommodation to fully participate in this program, I must obtain the Student Information and Requested Accommodation forms from Dr. Craig Jackson, Dean, School of Allied Health Professions in Nichol Hall, Room 1603.

Cognitive Learning Skills

I will be required to demonstrate the ability to:

1. Receive, interpret, remember, reproduce and use information in the cognitive, psychomotor, and affective domains of learning to solve problems, evaluate work, and generate new ways of processing or categorizing similar information listed in course objectives.
2. Assist in performing a physical therapy assessment of a patient's posture and movement including analysis of physiological, biomechanical, behavioral, and environmental factors in a timely manner, consistent with the acceptable norms of clinical settings.
3. Use evaluation data to execute a plan of physical therapy management, in a timely manner, appropriate to the plan developed by the physical therapist, consistent with acceptable norms of clinical settings.
4. Report to the physical therapist any changes in the patient that may require a reassessment or revision of plans as needed for effective and efficient management of physical therapy problems, in a timely manner and consistent with the acceptable norms of clinical settings.

Psychomotor Skills

I will be required to demonstrate the following skills.

1. Locomotion ability to:
    1. Get to lecture, lab and clinical locations, and move within rooms as needed for changing groups, partners and work stations.
    2. Physically maneuver in required clinical settings, to accomplish assigned tasks.
    3. Move quickly in an emergency situation to protect the patient, e.g. from falling.
2. Manual tasks:
    1. Maneuver another person's body parts to effectively perform treatment interventions.
    2. Manipulate common tools used for screening tests of the cranial nerves, sensation, range of motion, blood pressure, e.g., cotton balls, safety pins, goniometers, Q-tips, sphygmomanometer.
    3. Safely and effectively guide, facilitate, inhibit, and resist movement and motor patterns through physical facilitation and inhibition techniques (including ability to give time urgent verbal feedback).
    4. Manipulate another person's body in transfers, gait, positioning, exercise, and mobilization techniques. (Lifting weight up to 100 lbs). Involves bending and twisting by PTA student.
    5. Manipulate evaluation and treatment equipment safely and accurately apply to clients.
    6. Manipulate bolsters, pillows, plinths, mats, gait assistive devices, and other supports or chairs to aid in positioning, moving, or treating a patient effectively. (Lifting, pushing/pulling weights up to 100 lbs)
    7. Competently perform and supervise cardiopulmonary resuscitation (CPR) using guidelines issued by the American Heart Association for "Basic Life Support for Healthcare Providers".

3. Small motor/hand skills:
    1. Legibly record thoughts for written assignments and tests.
    2. Legibly record/document patient care notes and communications in standard medical charts in hospital/clinical settings in a timely manner and consistent with the acceptable norms of clinical settings.
    3. Detect changes in an individual's muscle tone, skin quality, joint play, kinesthesia, and temperature to report such changes to the physical therapist in a timely manner and sense that individual's response to environmental changes and interventions.
    4. Safely apply and adjust the dials or controls of therapeutic modalities
    5. Safely and effectively position hands and apply therapy interventions
    6. Use a telephone
4. Visual acuity to:
    1. Read written and illustrated material in the English language, in the form of lecture handouts, textbooks, web pages, literature and patient's chart.
    2. Observe active demonstrations in the classroom.
    3. Visualize training videos, projected slides/overheads, X-ray pictures, and notes written on a blackboard/whiteboard.
    4. Receive visual information from clients, e.g., movement, posture, body mechanics, and gait necessary for comparison to normal standards for purposes of assessing and reporting changes to physical therapist
    5. Receive visual information from treatment environment, e.g., dials on modalities and monitors, assistive devices, furniture, flooring, structures, etc.
    6. Receive visual clues as to the patient's tolerance of the intervention procedures. These may include facial grimaces, muscle twitching, withdrawal etc.
5. Auditory acuity to:
    1. Hear lectures and discussion in an academic and clinical setting.
    2. Distinguish between normal and abnormal breathing, lung and heart sounds using a stethoscope.
6. Communication:
    1. Effectively communicate information and safety concerns with other students, teachers, patients, peers, staff and personnel by asking questions, giving information, explaining conditions and procedures, or teaching home programs. These all need to be done in a timely manner and within the acceptable norms of academic and clinical settings.
    2. Receive and interpret written communication in both academic and clinical settings in a timely manner.
    3. Receive and send verbal communication in life threatening situations in a timely manner within the acceptable norms of clinical settings.
    4. Physical Therapy education presents exceptional challenges in the volume and breadth of required reading and the necessity to impart information to others. Students must be able to communicate quickly, effectively and efficiently in oral and written English with all members of the health care team.
7. Self care:
    1. Maintain general good health and self care in order to not jeopardize the health and safety of self and individuals with whom one interacts in the academic and clinical settings.
    2. Arrange transportation and living accommodations to foster timely reporting to the classroom and clinical assignments.

Affective Learning Skills

I must be able to:

1. Demonstrate respect to all people, including students, teachers, patients and medical personnel, without showing bias or preference on the grounds of age, race, gender, sexual preference, disease, mental status, lifestyle, opinions or personal values.
2. Demonstrate appropriate affective behaviors and mental attitudes in order not to jeopardize the emotional, physical, mental, and behavioral safety of clients and other individuals with whom one interacts in the academic and clinical settings and to be in compliance with the ethical standards of the American Physical Therapy Association.
3. Sustain the mental and emotional rigors of a demanding educational program in physical therapy, which includes academic and clinical components that occur within set time constraints, and often concurrently.
4. Acknowledge and respect individual values and opinions in order to foster harmonious working relationships with colleagues, peers, and patients/clients.

Signed: _____

Witnessed by: _____

Date: _____

APTA
American Physical Therapy Association

Last Updated: 10/15/13
Contact: advocacy@apta.org

Chart: Supervision of Students Under Medicare

Practice Setting	PT Student Part A	PT Student Part B	PTA Student Part A	PTA Student Part B
PT in Private Practice	N/A	X1	N/A	X1
Certified Rehabilitation Agency	N/A	X1	N/A	X1
Comprehensive Outpatient Rehabilitation Facility	N/A	X1	N/A	X1
Skilled Nursing Facility	Y1	X1	Y2	X1
Hospital	Y3	X1	Y3	X1
Home Health Agency	NAR	X1	NAR	X1
Inpatient Rehabilitation Agency	Y4	N/A	Y4	N/A

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

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.**

Y3: This is not specifically addressed in the regulations, therefore, please defer to state law and standards of professional practice. Additionally, the Part A hospital diagnosis related group (DRG) payment system is similar to that of a skilled nursing facility (SNF) and Medicare has indicated very limited and restrictive requirements for student services in the SNF setting.

Documentation: Please refer to documentation guidance provided under **Y1**

Y4: This is not specifically addressed in the regulations, therefore, please defer to state law and standards of professional practice. Additionally, the inpatient rehabilitation facility payment system is similar to that of a skilled nursing facility (SNF) and Medicare has indicated very limited and restrictive requirements for student services in the SNF setting.

X1: B. Therapy Students

1. General
Only the services of the therapist can be billed and paid under Medicare Part B. However, a student may participate in the delivery of the services if the therapist is directing the service, making the judgment, responsible for the treatment and present in the room guiding the student in service delivery.

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 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).

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.

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 patient/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 co-sign 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 therapy assistant students so long as the therapist assistant 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 the APTA at advocacy@apta.org or at 800.999.2782 ext. 8533.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C5-15-12
Baltimore, Maryland 21244-1850

December 20, 2019

Sharmila Sandhu	Kara Gainer	Sarah Warren
AOTA	APTA	ASHA
Director	Director	Director
Regulatory Affairs	Regulatory Affairs	Health Care Policy

Dear Ms. Sandhu, Ms. Gainer, and Ms. Warren:

We wanted to thank each of you and each of your respective organizations' representatives for meeting with us at the Centers for Medicare & Medicaid Services (CMS) on December 11, 2018, and for explaining your concerns regarding the hospital Conditions of Participation (CoPs), CMS Inpatient Rehabilitation Facility (IRF) payment and coverage policies, and the provision of rehabilitative services to patients by therapy students in hospitals (including IRFs).

As you stated in your letter and at the meeting, hospitals and IRFs provide critical training grounds for the future therapy workforce and these settings offer unique opportunities for students to see diverse patients and respond to various clinical challenges. We agree with this view and believe that practical clinical training in hospitals is essential for educating and providing not only future therapists, but also future physicians, nurses, pharmacists, advanced practice providers, and other professionals responsible for providing quality patient care. Therefore, to clarify our position on this subject, CMS has not changed its policy with regard to the CoPs and the provision of healthcare services by students in hospitals, including therapy students providing rehabilitative services in hospitals and IRFs.

Regarding the Medicare hospital CoPs, and specifically the Rehabilitation Services CoP at 42 CFR 482.56, no requirements or interpretive guidance exist that prohibit students (including, but not limited to, therapy students, medical students, nursing students, and other allied health students) from providing patient care services as part of their respective training programs. Under §482.56, the director of a hospital's rehabilitation services "must have the necessary knowledge, experience, and capabilities to properly supervise and administer the services" and must ensure that the services are "organized and staffed to ensure the health and safety of patients." The director's responsibilities would extend to all therapy students providing services to patients in the hospital as part of their training program.

Regarding the IRF intensive rehabilitation therapy program requirement in 42 CFR 412.622(a)(3)(ii), CMS's current policy does not prohibit the therapy services furnished by a therapy student under the appropriate supervision of a qualified therapist or therapy assistant from counting toward the intensive rehabilitation therapy program. However, IRFs provide a very intensive hospital level of rehabilitation therapy to some of the most vulnerable patients. To ensure the health and safety of this vulnerable population, CMS expects that all student therapy services will be provided by students under the supervision of a licensed therapist allowed by the hospital to provide such services.

Additionally, the CoPs at §§482.11, 482.12, and 482.22 hold the hospital responsible for the health and safety of patients through compliance with all federal, state, and local laws related to the health and safety of patients; ensuring that the medical staff is accountable to the governing body for the quality of care provided to patients; and having an organized medical staff that is responsible for the quality of medical care provided to patients by the hospital. By extension, any students providing services and care to patients within the hospital as part of a training program, their supervisory faculty, and any hospital staff acting as student preceptors would be subject to these levels of oversight within the hospital's organizational structure as well as any standards and requirements established by their respective training programs and by national organizations such as yours.

Sincerely,

Laurence D. Wilson
Director
Chronic Care Policy Group

John J. Thomas
Director
Clinical Standards Group

Appendix Two

Tab. 9 Course Descriptions

Tab.10 Year-at-a-Glance

Tab.11 Grading Policy

Tab.12 Standards for Satisfactory Completion of Clinical Experiences

Tab.13 Signature Page

LOMA LINDA UNIVERSITY
PHYSICAL THERAPIST ASSISTANT PROGRAM
Course Descriptions
2023 – 2024

SUMMER QUARTER

PTAS 201 Anatomy (4 units)
Anatomy of the human body, with emphasis on the neuromuscular and skeletal systems, including anatomical landmarks. Basic neuroanatomy of the central nervous system.

PTAS 205 Introduction to Physical Therapy (1 unit)
Physical therapy practice and the role of the physical therapist assistant in providing patient care. Quality assurance. Interpersonal skills. Introduction to the multidisciplinary team approach. Familiarization with health-care facilities and government agencies.

PTAS (206) Documentation Skills (1 unit)
Introduction to basic abbreviations, medical terminology, chart reading and note writing

PTAS 212 Physical Therapy Procedures (3 units)
Principles of basic skills in the physical therapy setting. Goniometry. Sensory, and gross muscle testing. Mobility skills in bed and wheelchair; and transfer training. Gait training and activities of daily living. Body mechanics, positioning and vital signs. Architectural barriers identified. Teaching techniques for other health care providers, patients, and families. Wheelchair measurement and maintenance. Lecture and laboratory.

PTAS 229 Physical Therapy Modalities (2 units)
Basic physical therapy modalities, including heat and cold application, hydrotherapy and massage, pool therapy, physiology and control of edema, stump wrapping, standard precautions, sterilization techniques, and chronic pain management. Lecture and laboratory.

PTAS 275 Psychosocial Aspects of Health (2 units)
Psychological and sociological reactions to illness or disability. Includes trauma, surgery, and congenital and terminal illness. Individual and family considerations.

RELE 257 Health Care Ethics (2 units)
Introductory exploration of the foundations, norms, and patterns of personal integrity in professional contexts.

FALL QUARTER

PTAS 203 Applied Kinesiology (3 units) Prerequisite PTAS 201
Introduction to functional anatomy of the musculoskeletal system. Application of biomechanics of normal and abnormal movement in the human body. Introduction to components of gait. Lecture and laboratory

PTAS 204 Applied Gait (1 unit) Introduces normal phases of gait. Identifies common gait abnormalities. Clinical application towards therapeutic exercises and gait training. Lecture and laboratory.

PTAS 224 General Medicine I (3 units)
Introduction to general medicine conditions, including pathology and management of medical problems. Diseases of the body systems, including urinary, reproductive, digestive, circulatory, nervous, endocrine, and musculoskeletal. Theoretical principles and practical application of respiratory techniques, exercises and postural drainage. CPR certification must be obtained before the end of the term.

PTAS 225 Neurology (3 units)
Introduction to neurological conditions, including pathology and management of medical problems of stroke, head injury, Parkinson's disease, spinal cord and nerve injuries and other conditions.

PTAS 227 Therapeutic Exercise (2 units)
Introduction to therapeutic exercise theories and practical applications. Tissue response to range-of-motion, stretch, and resistive exercise. Laboratory covers practical applications of various types of exercise techniques and machines used in the clinics, and a systematic approach to therapeutic exercise progression.

PTAS 264 Applied Orthotics and Prosthetics (2 units) Prerequisite PTAS 203
Introduction to basic principles in the use of selected prosthetic and orthotic devices. Exposure to various types of devices and adjustment to devices; examination of indications/contraindications for orthotic and prosthetic use with patients seen for PT.

AHCJ 305 Infectious Disease and the Health Care Provider (1 unit)
Current issues related to infectious disease, with special emphasis on the epidemiology and the etiology of HIV/AIDS. Discusses disease pathology and modes of transmission compared with hepatitis, tuberculosis, and influenza. Development of ethical response to psychosocial, economic and legal concerns. Impact on the health care worker; resources available; risk factors and precautions for blood-borne pathogens, HIV, hepatitis and tuberculosis.

WINTER QUARTER

PTAS 226 Orthopedics I (3 units)
Introduction to common orthopedic conditions, pathologies and surgical procedures of the peripheral joints. Joint mobilization techniques. Procedures and progression of therapeutic exercise for each specific joint will be covered as these exercises relate to tissue repair and healing response. Practical laboratory includes integration of treatment plans and progression. Successful completion of this course required prior to PTAS 251 Orthopedics II.

PTAS 234. General Medicine II (2 Unit)
Introduces students to and familiarizes them with equipment, lines, tubes, life-sustaining equipment, and procedures for the treatment of patients in the acute/inpatient setting. Considers various factors and reactions to medical procedures that may affect the treatment of patients in the acute care setting. Mobilization, functional mobility, exercise, and transfers within the acute care setting. Case scenarios with different situations that the physical therapist assistant may encounter in such acute care facilities as ICU, SNF, hospitals, and CCU. Identifies the roles of multidisciplinary team members managing critical care patients.

PTAS 236 Applied Electrotherapy (3 units)
Principles and techniques of electrotherapy procedures including basic physiological effects and indications and contraindications of specific electrotherapy modalities. Practical application and demonstration of modalities in a lecture and laboratory setting.

PTAS 238 Wound Care (1 unit)
Normal structure and function of the skin. Pathology of the skin, including problem conditions, burns, and wounds. Lecture and laboratory to include wound identification, measuring, dressing, treatments, and debridement. Model wounds used for hands on training.

PTAS 243 Applied Geriatrics (3 units)
Introduction to various aspects of geriatric care. Wellness care and adaptations to exercise modalities. Procedures pertaining to the geriatric patient. Diagnosis and aging changes that affect function in geriatric rehabilitation.

PTAS 252 Applied Neurology (3 units)
Introduction to facilitation techniques of neurological developmental treatment, proprioceptive neuromuscular facilitation, Brunnstrom and principles of therapeutic exercise of the cardiac patient. Practical laboratory.

PTAS 265 Professional Seminar (1 unit)
Contemporary theories and practices of physical therapy. Topics covered include: sports taping, ortho taping, soft tissue, affective learning. Lecture and laboratory.

RELR 275 Introduction to the Art & Science of Whole Person Care (2 units)
Principles, concepts, and practices that affect the ministry of health care and the Christian witness in the clinical setting.

SPRING QUARTER

PTAS 241 Applied Pediatrics (2 units)
Normal and abnormal development from conception to adolescence. Emphasis on developmental sequence, testing, and treatment of neurological and orthopedic disorders. Practical laboratory.

PTAS 251 Orthopedics II (4 units)
Prerequisite successful completion of PTAS 226 Orthopedics I. Introduction to common orthopedic conditions, pathologies and surgical procedures of the spine. Treatments, procedures, and progression of therapeutic exercises of the spine as related to tissue repair and healing response. Practical laboratory includes integration of treatment plans and progressions.

PTAS 261 Physical Therapy Practice (1 unit)
Observation of evaluations, treatments and various diagnosis. Billing procedures and third party payers. Completion of a resume and a state licensing application. Preparation and presentation of case study and in-service.

PTAS 293 Physical Therapist Assistant Clinical Experience I (6 units)
A six-week assignment to be completed during the spring quarter in affiliated clinical settings. Students will be exposed to a variety of clinical settings. Critique of clinical experience required. Forty clock hours per week of supervised clinical experience**.**

SUMMER QUARTER

PTAS 294 Physical Therapist Assistant Clinical Experience II (6 units)
A six-week assignment completed during the 1st half of the 2nd summer quarter in affiliated clinical settings. Students will be exposed to a variety of clinical settings. Critique of clinical experience required. Forty clock hours per week of supervised clinical experience**.**

PTAS 295 Physical Therapist Assistant Clinical Experience III (6 units)
A six-week assignment completed during the latter half of the 2nd summer quarter in affiliated clinical settings. Students will be exposed to a variety of clinical settings. Critique of clinical experience required. Forty clock hours per week of supervised clinical experience**.** The combined total of eighteen weeks of clinical experience prepares the student for entry-level performance.

Loma Linda University - Department of Physical Therapy
Physical Therapist Assistant Program
List of Required Skills: 2023-2024

DCS = Data Collection Skills **TS = Technical Skills**	**Lecture** **Course #/Term**	**Demonstrated** **Course #/Term**	**Skill Practice** **Course #/Term**	**Lab** **Assessed** **Course #/Term**
DCS: AEROBIC CAPACITY & ENDURANCE				
Recognize pupillary reactions, alertness, heart rate, blood pressure, respiratory rate, nausea, diaphoresis to positional changes	225[2] 224[2] 212[1] 236[3] 234[3]	224[2] 234[3] 212[1]	224[2] 234[3] 212[1]	224[2] 212[1]
Participation in administration of exercise protocols (e.g., treadmill, ergometer, 6-minute walk test, 3-min step test)	224[2] 227[2] 234[3]	224[2] 227[2]	224[2] 227[2]	224[2] 227[2]
Measure perceived exertion, dyspnea or angina during activity using RPE, dyspnea scale, anginal scale, or visual analog scale	224[2] 227[2] 234[3] 241[4]	224[2] 227[2]	224[2] 227[2]	227[2]
Measurement of standard vital signs (blood pressure, HR, RR) at rest, during and after activity	241[4] 236[3] 227[2] 212[1]	227[2] 224[2] 212[1]	227[2] 224[2] 212[1]	227[2] 224[2] 241[4] 212[1]
Observe T-A movements & breathing patterns with ex, without stethoscope.	224[2]	224[2]	224[2]	
Auscultation of lung sounds	224[2]	224[2]	224[2]	224[2]
Palpation of pulses	236[3] 224[2] 212[1]	224[2] 212[1]	224[2] 212[1]	224[2] 212[1]
Performance of claudication time tests	224[2]	224[2]	224[2]	
Performance of pulse oximetry	224[2]	224[2]	224[2]	
DCS: ANTHROPOMETRIC CHARACTERISTICS				
Describe activities and postures that effect edema	264[2] 236[3] 238	236[3]	229[1]	
Recognize changes in edema	229[1] 236[3] 238	229[1] 236[3]	229[1]	
Measure edema through girth and palpation	212[1] 224[2] 236[3]	212[1] 236[3]	212[1]	212[1]
Recognize that body-fat comp may be measured using calipers	224[2]			
Measure height, weight, length, girth	224[2]	212[1] 224[2]	212[1] 224[2]	212[1]
Recognize normal alignment of trunk and extremities at rest and during activities	203[2] 212[1] 241[4] 251[4]	203[2] 212[1] 224[2] 241[4] 251[4]	203[2] 212[1] 224[2] 241[4] 251[4]	241[4] 251[4] 212[1]
DCS: AROUSAL, MENTATION, AND COGNITION				
Recognize changes in the direction and magnitude of patient's state of arousal, attention, mentation, and cognition	241[4] 225[2]	241[4] 224[2]	224[2] 241[4]	
Identify factors influencing motivation	275[1] 241[4]	241[4]	241[4]	
Recognize patient's level of recall (short-term, long-term memory	225[2] 243[3]	243[3]	243[3]	
Recognize patient's orientation to time, person, place and situation	225[2] 243[3]	243[3] 224[2]	243[3] 224[2]	
Determination of ability to process commands	225[2] 241[4]	243[3] 224[2] 241[4]	243[3] 224[2] 241[4]	
Identification of patient's gross expressive and receptive deficits	241[4] 225[2]	243[3] 241[4]	243[3] 241[4]	
DCS: ASSISTIVE AND ADAPTIVE DEVICES				
Identify client and caregiver ability to care for device	212[1] 241[4]	212[1]	212[1]	212[1]
Recognition of alignment/fit of device and inspection of related skin changes	264[2] 241[4] 212[1] 236[3]	264[2] 236[3] 241[4]	236[3] 241[4] 204[2]	241[4]
Measure appropriate components of the device	212[1] 241[4] 264[2]	212[1] 241[4]	212[1] 261[4]	212[1] 241[4]
Recognition of safety factors while using the device	264[2] 241[4] 212[1]	264[2] 241[4] 212[1] 224[2]	212[1] 224[2] 261[4]	212[1]
Observe client for use of device for intended effects and benefits	264[2] 241[4] 212[1]	264[2] 241[4] 212[1]	212[1] 261[4]	212[1] 241[4]
Review of reports from client, family, sig other, caregiver, etc	264[2]	224[2]	224[2]	
DCS: COMMUNITY & WORK INTEGRATION/REINTEGRATION				
Administration of standard questionnaires with patients and others	243[3]	243[3]	243[3]	
Administration of scales/indices of instrumental ADLs per POC	252[3] 226[3] 251[4]			
Observation of adaptive skills	241[4]	241[4]	241[4]	241[4]
Observation of community, work (job/school/play), and leisure activities	264[2]	264[2]		
---and with assistive/adaptive/orthotic/protect/supp/prosthetic devices/equip	264[2]	264[2]		
Observation of environment and work tasks	264[2] 251[4]	264[2]		
Recognition of safety in community and work environments	264[2] 251[4]	264[2]		
Review of reports from client, family, sig other, caregiver, etc	264[2]			
DCS: CRANIAL NERVE INTEGRITY & SENSORY INTEGRITY				
Identify response to auditory stimuli	225[2] 241[4]	241[4]	241[4]	
Recognize response to visual stimuli	225[2] 241[4]	241[4]	241[4]	
Determination of gross expressive (verbalization) abilities	225[2] 241[4]	241	241[4]	
Determination of superficial sensations (e.g., sharp/dull, temp, light touch)	212[1] 236[3] 251[4] 226[3] 225[2]	212[1] 236[3] 251[4] 226[3] 225[2]	212[1] 236[3] 251[4] 226[3]	212[1] 226[3] 236[3] 251[4]
DCS: ENVIRONMENTAL, HOME AND WORK BARRIERS				

List of Required Skills: 2023-2024

DCS = Data Collection Skills **TS = Technical Skills**	**Lecture Course #/Term**	**Demonstrated Course #/Term**	**Skill Practice Course #/Term**	**Lab Assessed Course #/Term**
Recognition of present and potential barriers and possible modifications	212[1] 264[2] 243[3]	212[1] 264[2]	212[1]	
Measurement of physical space	212[1]	212[1]	212[1]	
Physical inspections of the environment	212[1] 243[3] 236[3]	212[1]	212[1]	
DCS: ERGONOMICS AND BODY MECHANICS				
Measurement of height, weight, length, girth	212[1] 224[2]	212[1] 224[2]	212[1] 224[2]	212[1]
DCS: GAIT, LOCOMOTION AND BALANCE				
Administration of balance and gait analysis instruments	204[2] 252[3]	252[3] 204[2]	252[3] 204[2]	252[3] 204[2]
Administration of functional gait/locomotion tools/profiles	204[2]	204[2]	204[2]	204[2]
Recognition effects of terrain/environments on pt's gait/locomotion/balance	225[2] 241[4]	241[4]	241[4]	
Demonstrate wheelchair management and mobility	212[1] 241[4]	212[1] 241[4]	212[1]	212[1]
Describe safety of patient: gait/locomotion/balance/wc management/mobility	264[2] 241[4]	241[4]	241[4]	241[4]
Identify normal and abnormal gait characteristics	204[2] 264[2]	204[2] 264[2] 241[4] 252[3]	204[2] 264[2] 241[4] 252[3]	204[2] 241[4] 252[3]
Identify normal and abnormal characteristics of static/dynamic balance	264[2] 225[2] 251[4] 252[3] 226[3]	225[2] 264[2] 224[2] 241[4] 252[3] 226[3]	225[2] 264[2] 224[2] 241[4] 252[3] 226[3]	225[2] 241[4] 252[3] 226[3]
DCS: INTEGUMENTARY INTEGRITY – for skin				
Observation for absence or presence of hair growth	238[3] 251[4]			
Recognition of activities/positioning/postures that +/- pain/disturbed sensations	212[1] 236[3] 251[4] 241[4] 238[3]	236[3] 251[4] 241[4] 212[1]	251[4] 241[4]	241[4]
Recognition of activities/positioning/postures re: assist/adaptive devices	264[2] 212[1] 251[4]	264[2] 241[4]	241[4]	241[4]
Observation of continuity of skin color (eg, redness/violescence	238[3] 212[1] 251[4] 229[1] 236[3] 241[4]	229[1] 236[3]	229[1] 236[3]	229[1] 236[3] 241[4]
Observation of nail beds	241[4]			
Measurement of sensation (e.g., pain, temperature, tactile)	212[1] 236[3] 251[4] 238[3] 226[3]	212[1] 236[3] 251[4] 226[3]	212[1] 236[3] 251[4] 226[3]	236[3] 212[1] 226[3] 251[4]
Comparison of skin temperature or opposite extremity by palpation	226[3] 236[3] 251[4] 238			
DCS: INTEGUMENTARY INTEGRITY – for wound				
Observation for blistering	264[2] 238[3]	264[2]		
Identification for burn	236[3] 264[2] 238[3]	236[3] 264[2]	236[3]	236[3]
Observation for dermatitis	238[3]			
Observation for ecchymosis	264[2] 238[3]	264[2]		
Observation for absence or presence of hair growth	238[3]			
Observation for signs of infection	236[3] 264[2] 241[4] 238[3]	236[3] 264[2] 238[3]	236[3] 238[3]	236[3] 241[4] 238[3]
Recognition of activities/positioning/postures that +/- wound/scar/new trauma	264[2] 236[3] 238[3]	264[2]		
Observation of bleeding	236[3] 238[3]	236[3]	236[3]	236[3]
Observe exposed anatomical structures	238[3]			
Observation of pigment	238[3]			
Measurement of sensation (e.g., pain, temperature, tactile)	212[1] 234[3] 236[3] 238[3]	212[1] 236[3] 234[3]	212[1] 236[3] 234[3]	236[3] 212[1]
Observation of scar tissue (cicatrix) incld banding/pliability/sensation/texture	238[3]			
Observation of wound contraction/drainage/location/odor/shape/size depth	236[3] 238[3]	238[3]	238[3]	
DCS: MOTOR FUNCTION				
Describe head, trunk, and limb movement	241[4] 203[2] 251[4]	241[4] 203[2] 251[4]	241[4] 203[2] 251[4]	241[4] 203[2] 251[4]
Identification of stereotypic movements	241[4] 251[4] 225[2] 252[3]	241[4] 251[4] 225[2] 252[3]	241[4] 251[4] 225[2] 252[3]	241[4] 251[4] 252[3]
Recognize autonomic responses of pupillary reactions/alertness /HR/ BP/RR/ nausea/diaphoresis to positional changes	224[2] 225[2]	224[2] 234[3]	224[2] 234[3]	
Identification of postural, equilibrium, righting reactions	225[2] 241[4]	225[2] 241[4] 252[3]	225[2] 241[4] 252[3]	241[4] 252[3]
DCS: MUSCLE PERFORMANCE (incld strength, power, endurance)				
Measurement of functional muscle strength, power, and endurance	212[1] 226[3] 252[4] 227[2] 251[4]	212[1] 226[3] 252[4] 251[4]	212[1] 226[3] 252[4] 251[4]	212[1] 226[3] 252[4] 251[4]
Measurement of muscle strength/power/endurance; manual test/ dynamometry	212[1] 226[3] 252[4] 234[3]	212[1] 226[3] 252[4] 234[3]	212[1] 226[3] 252[4]	212[1] 226[3] 252[4]
Identification of muscle tone and mass	225[2] 241[4] 252[3] 226[3]	225[2] 241[4] 252[3] 226[3]	225[2] 241[4] 252[3] 226[3]	241[4] 252[3]

List of Required Skills: 2023-2024

DCS = Data Collection Skills **TS = Technical Skills**	**Lecture** **Course #/Term**	**Demonstrated** **Course #/Term**	**Skill Practice** **Course #/Term**	**Lab** **Assessed** **Course #/Term**
Recognition of pain and soreness	224² 234³ 236³ 226³ 251⁴ 227²	224² 234³ 236³ 226³ 251⁴ 227²	224² 234³ 236³ 226³ 251⁴ 227²	236³ 226³ 251⁴ 227²
DCS: NEUROMOTOR DEVELOPMENT & SENSORY INTEGRATION				
Recognition of equilibrium and righting reactions	225² 241⁴	225² 241⁴	225² 241⁴	241⁴ 252³
Recognition of gross and fine motor skills	241⁴ 227²	241⁴	241⁴	241⁴
DCS: ORTHOTIC, PROTECTIVE, AND SUPPORTIVE DEVICES				
Recognition of changes in skin condition after use of an orthotic device	264² 241⁴ 238³	264²	241⁴	241⁴
Describe components of an orthotic device	264² 241⁴ 203² 226³ 251⁴	264² 241⁴	264² 241⁴	241⁴
Recognize safety of patient while using a device	264² 241⁴	264² 241⁴	264² 241⁴	241⁴
Identification of the ability of the individual to don/remove/care for orthotics	264²	264²	264²	
Review of reports from client, family, sig other, caregiver, etc	264² 241⁴	264²	264² 241⁴	241⁴
DCS: PAIN				
Recognize pain behavior and reaction during specific movements	264² 236³ 241⁴ 251⁴ 238³ 227²	264² 226³ 251⁴ 238³ 227²	264² 226³ 251⁴ 227²	226³ 251⁴ 241⁴ 227²
Recognize muscle soreness during specific movements	236³ 226³ 227² 251⁴	226³ 251⁴ 227²	226³ 251⁴ 227²	226³ 251⁴
Describe pain and soreness with joint movement	236³ 241⁴ 227²	227²	227²	226³ 251⁴ 241⁴ 227²
Describe pain perception (e.g., phantom pain)	264² 229¹ 236³			
Administration of questionnaires, graphs, behavioral scales, or VAS for pain	238³ 229¹ 236³	238³ 226³ 251⁴	226³ 251⁴	226³ 251⁴
DCS: PERIPHERAL JOINT INTEGRITY AND MOBILITY				
Describe normal and abnormal movement of the peripheral joint or extremity during performance of specific movement tasks	226³ 241⁴ 203²	226³ 241⁴ 203²	226³ 241⁴	241⁴ 226³
Identify peripheral joint hypomobility and hypermobility	226³ 241⁴ 227² 212¹ 203	226³ 241⁴ 203² 227	226³ 241⁴ 203² 227	226³ 241⁴ 203² 227
Recognize pain and soreness	241⁴ 212¹ 236³ 226³ 227²	226³ 241⁴ 227²	226³ 241⁴ 227²	226³ 241⁴ 227²
Identifies soft tissue restrictions	212¹ 236³ 226³	212¹ 226³	212¹ 226³	226³
DCS: POSTURE				
Describe resting posture in any position	241⁴ 224² 251⁴ 212¹ 236³ 226³	236³ 251⁴ 241⁴ 212¹ 226³	251⁴ 212¹ 241⁴ 226³	251⁴ 212¹ 241⁴ 226³
DCS: PROSTHETIC REQUIREMENTS				
Describe components of a prosthetic device	264²	264²	264²	
Recognize safety of patient while using a prosthetic device	264²	264²	264²	
Identification of changes in skin condition	264² 238³	264²	264²	
Identification of the ability of the individual to don/remove/care for prosthesis	264²	264²	264²	
Measurement of residual limb and/or adjacent segment for ROM and strength	264²	264²	264²	
Review of reports from client, family, sig other, caregiver, etc	264²	264²		
DCS: RANGE OF MOTION (INCLD MUSCLE LENGTH)				
Measurement of functional ROM	212¹ 226³ 251⁴ 241⁴	212¹ 226³ 251⁴ 241⁴	212¹ 226³ 251⁴ 241⁴	212¹ 241⁴ 252³
Measurement of ROM using goniometer/tape measure/flex ruler/inclinometer	212¹ 226³ 251⁴	212¹ 226³ 251⁴ 241⁴	212¹ 226³ 251⁴ 241⁴	212¹ 226³ 251⁴
Observation of muscle, joint, or soft tissue characteristics	241⁴ 212¹ 226³ 251⁴	212¹ 226³ 251⁴	212¹ 226³ 251⁴	212¹ 226³ 251⁴
DCS: SELF-CARE & HOME MGMT (incld BADL and IADL training)				
Administration of standard questionnaires with the patient and others	*Skill is addressed on p. 1, under "Community and Work"*			
Administration of scales or indices as provided by the PT of BADLs or IADLs	*Skill is addressed on p. 1, under "Community and Work"*			
Observation of adaptive skills	*Skill is addressed on p. 1, under "Community and Work"*			
Observation of self-care and home-management activities using assistive/adaptive/orthotic/protective/supportive/prosthetic devices/equip	264²	264²	264²	
Recognition of ability to transfer	243³	243³	243³	243³
Recognize autonomic responses of pupillary reactions/alertness /HR/ BP/RR/ nausea/diaphoresis to positional changes	225²			
Review of daily activities logs or reports of client, family, sig other, caregiver	225²			

List of Required Skills: 2023-2024

DCS = Data Collection Skills TS = Technical Skills	Lecture Course #/Term	Demonstrated Course #/Term	Skill Practice Course #/Term	Lab Assessed Course #/Term
DCS: VENTILATION, RESPIRATION, CIRCULATION				
Measurement of edema through volumetrics and girths	212[1] 236[3]			
Recognition of cyanosis	241[4] 224[2] 236[3]	224[2] 241[4] 234[3]	224[2] 241[4] 234[3]	241[4]
Recognition of activities that +/- edema, pain, dyspnea or other symptoms	241[4] 224[2] 234[3] 236[3]	224[2] 241[4] 234[3]	224[2] 241[4] 234[3]	234[3] 241[4]
Observation of cardiopulmonary response to performance of BADLs /IADLs	224[2] 234[3]	234[3]	234[3]	234[3]
Observation of chest wall mobility, expansion, excursion	224[2] 241[4]	224[2]	224[2]	241[4]
Observation of cough and sputum	224[2] 241[4]	224[2]	224[2]	241[4]
Measurement of standard vital signs at rest and during/after activity	241[4] 234[3] 236[3]	227[2] 234[3] 241[4]	227[2] 234[3] 241[4]	234[3] 241[4]
Palpation of pulses	227[2] 234[3]	227[2] 234[3] 224[2]	227[2] 234[3] 224[2]	227[2] 234[3]
Performance of pulse oximetry	234[3]	234[3]	234[3]	
TS: THERAPEUTIC EXERCISE (including aerobic conditioning)				
Aerobic endurance activities using ergometers, treadmills, steppers, pulleys, weights, hydraulics, elastic resistance bands or electromechanical devices	227[2] 224[2]	227[2] 224[2]	227[2] 224[2]	227[2]
Aquatic exercises	229[1] 227[2]	229[1] 227[2]	229[1] 227[2]	
Balance and coordination training	227[2] 252[3] 226[3] 241[4] 227[2]	241[4] 252[3] 226[3] 227[2]	252[3] 226[3] 241[4] 227[2]	252[3] 226[3] 241[4] 227[2]
Body mechanics	212[1] 252[3] 241[4] 227[2]	212[1] 252[3] 234[2] 229[1] 241[4] 227[2]	212[1] 252[3] 234[2] 229[1] 241[4] 227[2]	252[3] 227[2] 251[4]
Breathing exercises	224[2]	224[2]	224[2]	
Breathing strategies (e.g., paced breathing, pursed lip breathing)	224[2]	224[2]	224[2]	
Conditioning and reconditioning	227[2]	227[2]	227[2]	227[2]
Developmental activities training	241[4] 252[3]	241[4] 252[3]	241[4] 252[3]	241[4] 252[3]
Gait and elevation training	212[1] 204[3] 243[3]	212[1] 204[3] 243[3]	212[1] 204[3] 243[3]	204[3] 212[1]
Mobility training on even/uneven terrains in various physical environments	212[1] 241[4]	212[1] 241[4]	212[1] 241[4]	212[1] 241[4]
Motor training or retraining	241[4] 252[3] 236[3] 227[2]	241[4] 252[3] 236[3] 227[2]	252[3] 236[3] 227[2] 241[4]	252[3] 236[3] 227[2] 241[4]
Neuromuscular re-education	252[3] 236[3] 227[2] 241[4]	252[3] 236[3] 227[2] 241[4]	252[3] 236[3] 227[2] 241[4]	252[3] 236[3] 227[2] 241[4]
Neuromuscular relaxation, inhibition, and facilitation	241[4] 252[3] 236[3]	252[3] 236[3] 241[4]	252[3] 236[3] 241[4]	252[3] 236[3] 241[4]
Perceptual training	225[2] 252[3]	225[2] 252[3]		
Postural awareness training	241[4] 236[3] 251[4] 226[3]	251[4] 241[4] 226[3]	251[4] 241[4] 226[3]	251[4] 241[4] 226[3]
Sensory training or retraining	236[3] 241[4] 225[2]	226[3]	226[3]	241[4]
Strengthening: active	227[2] 252[3] 236[3] 241[4] 226[3] 251	227[2] 252[3] 241[4] 226[3] 251[4]	227[2] 252[3] 241[4] 226[3] 251[4]	227[2] 252[3] 241[4] 226[3] 251[4]
Strengthening: active assistive	236[3] 241[4] 252[3]	241[4] 252[3]	241[4] 252[3]	227[2] 241[4] 252[3]
Strengthening: resistive, using manual resistance, pulleys, weights, hydraulics, elastic resist bands and mechanical or electromechanical devices	227[2] 252[3] 226[3] 251[4]	227[2] 252[3] 226[3] 251[4]	227[2] 252[3] 226[3] 251[4]	227[2] 252[3] 226[3] 251[4]
Stretching	241[4] 227[2] 252[3] 226[3] 251[4]	241[4] 227[2] 252[3] 226[3] 251[4]	241[4] 227[2] 252[3] 226[3] 251[4]	227[2] 252[3] 241[4] 226[3] 251[4]
Structured play or leisure	241[4] 241[4]	241[4]	241[4]	241[4]
ADL training (e.g., bed mobility/transfers/gait/locomotion/developmental activity/dressing/bathing/eating/toileting)	243[3] 234[3] 252[3] 241[4]	243[3] 234[3] 252[3] 241[4]	243[3] 234[3] 252[3] 241[4]	243[3] 234[3] 252[3] 241[4]
Assistive and adaptive devices and equipment training	234[3] 243[3] 241[4]	234[3] 243[3] 241[4]	243[3] 241[4]	243[3] 241[4]
Body mechanics training	252[3] 227[2]	252[3] 241[4] 227[2]	227[2] 252[3] 241[4]	251[4] 252[3] 241[4]
Organized functional training programs (e.g., back schools, simulated environments and tasks)	251[4]			
Orthotic, protective or supportive devices training	264[2] 241[4]	264[2]	264[2]	
Prosthetic training	264[2]	264[2]	264[2]	
TS: FUNCTIONAL TRAINING IN COMM OR WORK INTEGRATION/ REINTEGRATION (including IADL, work hardening/conditioning)				
Body mechanics training	212[1] 251[4]	251[4] 229[1]	227[2] 251[4] 229[1]	251[4]
Dexterity and coordination training	212[1]	212[1]	212[1]	
IADL (e.g., shopping, cooking, light/heavy household chores, structured play for infants/children/negotiating school environments	212[1]	212[1]	212[1]	
Organized functional training programs (e.g., back schools, simulated environments and tasks)	251[4]			
Postural awareness training	241[4] 251[4]	251[4]	251[4]	
TS: MANUAL THERAPY TECHNIQUES				
Connective and soft tissue	236[3] 251[4]	251[4]	251[4]	226[3] 251[4]
Passive range of motion	227[2] 241[4] 236[3]	227[2] 241[4]	227[2] 241[3]	227[2] 241[4]

List of Required Skills: 2023-2024

DCS = Data Collection Skills **TS = Technical Skills**	**Lecture Course #/Term**	**Demonstrated Course #/Term**	**Skill Practice Course #/Term**	**Lab Assessed Course #/Term**
Therapeutic massage	229[1] 241[4]	229[1] 241[4]	229[1] 241[4]	229[1] 241[4]
TS: RECOMMENDATION & APPLICATION OF DEVICES/EQUIPMENT				
Adaptive devices (e.g., raised toilet seats, seating systems, environmental controls, etc)	225[2] 212[1] 226[3] 251[4]	234[3]	234[3]	
Assistive devices (e.g., crutches, canes walkers, wheelchairs, power devices, long handled reaches, static and dynamic splints)	241[4] 243[3] 226[3] 212[1]	241[4] 243[3] 212[1] 234	241[4] 243[3] 212[1] 234[3]	241[4] 243[3] 212[1]
Orthotic devices (e.g., splints, braces, shoes inserts, casts)	251[4] 264[2] 238[3] 241[4] 226[3] 203[2]	264[2] 241[4]	264[2] 241[4]	241[4]
Prosthetic devices for lower extremities	264[2] 241[4]	264[2]	264[2] 241[4]	241[4]
Protective devices (e.g., braces, taping, cushions, helmets)	264[2] 241[4]	264[2] 241[4]	264[2] 226[3] 251[4]	
Supportive devices (e.g., taping, compression garments, corsets, slings, neck collars, serial casts, elastic wraps, oxygen)	264[2] 225[2] 241[4] 238[3]	264[2] 234[3] 238[3]	264[2] 229[1] 226[3] 261[4] 234[3] 251[4]	
TS: AIRWAY CLEARANCE TECHNIQUES				
Assistive cough techniques (incl huffing, maximal inspir hold, coughing)	225[2] 224[2]	224[2]	224[2]	
Breathing strategies incl techniques to maximize ventilation	224[2] 241[4]	224[2]	224[2]	
Chest percussion, vibration, shaking, and coughing	224[2] 241[4]	224[2]	224[2]	224[2]
Postural drainage and positioning	224[2] 241[4]	224[2]		224[2]
TS: WOUND MANAGEMENT				
Assistive and adaptive devices	238[3]			
Debridement-nonselective: enzymes	238[3]			
Debridement-nonselective: wet dressings	238[3]			
Debridement-nonselective: wet-to-dry dressings	238[3]			
Debridement-nonselective: wet-to-moist dressings	238[3]			
Debridement-selective: debridement with other agents (e.g., autolysis)	236[3] 238[3]	238[3]	238[3]	238[3]
Debridement-selective: enzymatic debridement	238[3]	238[3]		238[3]
Dressings (e.g., wound coverings, hydrogels)	238[3]	238[3]		238[3]
Orthotic, protective or supportive devices	264[2] 238[3]	264[2]		
Topical agents (e.g., ointments, moisturizers, creams, cleansers, sealants)	238[3]	238[3]		238[3]
TS: ELECTROTHERAPEUTIC MODALITIES				
Biofeedback	236[3]	236[3]	236[3]	236[3]
Electrical muscle stimulation	236[3]	236[3]	236[3]	236[3]
Functional electrical stimulation (FES)	225[2] 236[3]	236[3]	236[3]	236[3]
Iontophoresis	236[3]	236[3]	236[3]	236[3]
TS: PHYSICAL AGENTS and MECHANICAL MODALITIES				
Athermal modalities (e.g., pulsed US and EM fields)	236[3] 238	236[3]	236[3]	236[3]
Cryotherapy modalities (e.g., cold packs, ice massage, vapocoolant spray)	236[3]	236[3]	236[3]	229[1]
Deep thermal modalities (e.g., ultrasound, phonophoresis)	236[3] 238	236[3]	236[3]	236[3]
Hydrotherapy (aquatic tx, whirlpool, tanks, contrast baths, pulsatile lavage)	238[3] 236[3] 229[1]	229[1] 238	229[1]	229[1]
Phototherapies (e.g., ultraviolet)	236[3] 238[3]			
Superficial thermal modalities (e.g., heat, paraffin baths, hot packs)	229[1]	229[1]	229[1]	229[1]
Compression therapies (e.g. vasopneumatic compression devices, compression bandaging, compression garments, taping)	234[3] 264[2] 236[3] 238[3] 229[1]	264[2] 238[3] 229[1]	264[2] 238[3] 229[1]	229[1] 238[3]
Continuous passive motion (CPM)	234[3] 227[2]	234[3]	234[3]	
Tilt table or standing table	252[3]			
Traction (sustained, intermittent or positional)	251[4]	251[4]	251[4]	251[4]

Note: The *LLU PTA Program Comprehensive Skills List* is adapted from the APTA *Minimum Required Skills of Physical Therapist Assistant Graduates at Entry-Level,* BOD G11-08-09-18 (12/5/08)

LOMA LINDA UNIVERSITY

PHYSICAL THERAPIST ASSISTANT PROGRAM

Curriculum Year-at-a-Glance

2023-2024

SUMMER	**12 WEEKS**	**Monday, June 19 – Sept 08, 2023**	**Units**	**Instructor**
	PTAS 201	Anatomy *(with lab)*	4	Ron Rea
	PTAS 205	Intro to Physical Therapy	1	Sue Huffaker
	PTAS 206	Documentation Skills	1	Sue Huffaker
	PTAS 212	P.T. Procedures *(with lab)*	3	Henry Garcia
	PTAS 229	P.T. Biophysical Agents *(with lab)*	2	Pablo Mleziva
	PTAS 275	Psychosocial Aspects of Health	2	Edna Barrett
	PTAS 265	Professional Seminar	0	Jeremy Hubbard
	RELE 257	Health Care Ethics	2	SR Faculty
		SUMMER QUARTER TOTAL	**15**	
AUTUMN	**12 WEEKS**	**Sept 25 – Dec 15, 2023**		
	PTAS 203	Applied Kinesiology *(with lab)*	3	Ron Rea
	PTAS 204	Applied Gait *(with lab)*	1	Sue Huffaker
	PTAS 224	General Medicine I *(with lab)*	3	Pablo Mleziva
	PTAS 225	Neurology	3	Sue Huffaker Ron
	PTAS 227	Therapeutic Exercise *(with lab)*	2	Rea Michael
	PTAS 264	Applied Orthotics & Prosthetics *(with lab)*	2	Davidson Jeremy
	PTAS 265	Professional Seminar	0	Hubbard SAHP
	AHCJ 305	Infectious Disease & the Healthcare Provider	1	Faculty
		AUTUMN QUARTER TOTAL	**15**	
WINTER	**11 WEEKS**	**Jan 02 – March 15, 2024**		
	PTAS 226	Orthopedics *(with lab)*	3	Ron Rea
	PTAS 234	General Medicine II *(with lab)*	2	Pablo Mleziva
	PTAS 236	Applied Electrotherapy *(with lab)*	3	Ron Rea Melanie
	PTAS 238	Wound Care	1	Grove Bruce
	PTAS 243	Applied Geriatrics *(with lab)*	3	Bradley Sue
	PTAS 252	Applied Neurology *(with lab)*	3	Huffaker Jeremy
	PTAS 265	Professional Seminar	0	Hubbard
	RELR 275	Intro to Art & Science of Whole Person Care	2	SR Faculty
		WINTER QUARTER TOTAL	**17**	
SPRING	**11 WEEKS**	**March 25 – June 07, 2024** ***(On-campus courses resume May 6)***		
	PTAS 293	PTA Clinical Experience I (6 wks Mar 25 – May 3)	3, 6	Jenni Rae Rubio
	PTAS 241	Applied Pediatrics *(with lab)*	2	Edna Barrett
	PTAS 251	Orthopedics II *(with lab)*	3	Ron Rea
	PTAS 261	P.T. Practice	1	Sue Huffaker
	PTAS 265	Professional Seminar	1	Jeremy Hubbard
		SPRING QUARTER TOTAL	**10, 13**	

Sunday, June 9, 2024 Graduation Ceremonies for LLU/SAHP/Department of Physical Therapy

SUMMER	**12 WEEKS**	**July 01 – Sept 20, 2024**		
	PTAS 294	PTA Clinical Experience II (6 wks July 01 – Aug 9)	3, 6	Jenni Rae Rubio
	PTAS 295	PTA Clinical Experience III (6 wks Aug 12 – Sep 20)	3, 6	Jenni Rae Rubio
		SUMMER QUARTER TOTAL	**6, 12**	

TOTAL UNITS: 63 tuition units, 72 academic credit units

OPERATING POLICY

CATEGORY:	Academics	CODE:	A-8
		EFFECTIVE:	8/19/2013 8/6/2012
SUBJECT:	Grading- Clinical Experiences	REPLACE:	7/12/2021 8/19/2013 8/6/2012 8/3/2011
DEPARTMENT:	Physical Therapy	PAGE:	1 of 2
COORDINATOR:	DEPARTMENT CHAIR		

The sources of data listed below are used by the Director of Clinical Education (DCE) and Clinical Education Committee (CEC) in assigning a grade for a clinical experience. As the faculty representation for matters of clinical education experiences, the CEC has the right to and may obtain input from additional faculty members in assessing the overall student performance and assigning the grade. Data gathered from the following will inform the grading process:

1. Physical Therapist/Physical Therapist Assistant Clinical Performance Instrument (CPI) or the Short Clinical Experience Evaluation Form (for the DPT Program). Both the assessment by the Clinical Instructor as well as the student self-assessment will be reviewed.
2. Interviews conducted by academic faculty with the Site Coordinator for Clinical Education (SCCE), Clinical Instructor (CI) and the student.
3. Documentation of all required assignments as outlined in the Course Syllabus/Outline.

The CPI and the Short Clinical Experience Evaluation Form include criteria and rating scales/standards upon which the students' performance is represented. Space is also provided for each criterion where the CI could document narrative comments.

Students are expected to demonstrate attributes, characteristics and behaviors that are not explicitly part of the professional core of knowledge and technical skills but are nevertheless required for success in the profession. The APTA has identified behaviors [Core Values/Values-based behavior] that are integral to the satisfactory completion of a clinical experience. The CEC will reference these APTA sources to substantiate the decision for grading as deemed necessary.

The program has defined standards for each criterion which indicate satisfactory (S) completion of each specific clinical experience. (See *Standards for Satisfactory Completion of Long Clinical Experience* and *Standards for Satisfactory Completion of Short Clinical Experiences, and Standards for Satisfactory Completion of Clinical Experiences PTA*). The Clinical Instructor does not determine the final grade for the clinical experience but provides valuable assessment of student onsite performance in terms of each clinical criterion observed.

The clinical experiences are graded as Satisfactory (S), Unsatisfactory (U) and on rare occasions, Incomplete (I). In the very rare event that a course withdrawal occurs during the period allowed for significantly extenuating circumstances a Withdrawal (W) will be the designated transcript entry. Each student is expected to receive a satisfactory rating by the end of each clinical rotation. Each rotation is independent of the others and

must be satisfactorily completed. Errors in safety and/or judgment and unprofessional behavior may be grounds for the student to be removed from the facility.

If the clinical faculty (CI and SCCE) find that the student is not meeting the requirements or expectations for the clinical experience, the CI or SCCE should contact the DCE for more in-depth and collaborative assessment and development of a plan of action towards a more amenable outcome.

The following are examples of conditions presenting grounds for an Unsatisfactory (U) Grade:

1. The student terminates the clinical experience without authorization of DCE/CEC.

2. The student fails to attain Satisfactory Program Standards as assessed using the respective CPI/Short Clinical Experience Evaluation Form.

> *Note: failure to attain the standard for as few as one (1) criterion could result in an Unsatisfactory (U) grade. Performance scores which do not meet the standard are reviewed by the DCE in conjunction with the CEC in determining the final grade.*

3. The student fails to complete, with appropriate signatures and dates, and submit all required documents and assignments associated with the clinical experience by 5:00 p.m., on the MONDAY after the last scheduled date of the clinical rotation. The documents may include but are not limited to the CPI, Short Clinical Experience Evaluation Form, In-service / Project Report, and Reflection Paper ***A "U" grade entered under this condition may be remediated by submission of completed documents and re-registration.*** *(The tuition/fees would be calculated at half the price of the regular fees).*

4. The student commits an egregious offense e.g., stealing, sexual harassment, fraud, professional misconduct such as inappropriate public postings on public social networks such as Facebook ® and Twitter ®.

5. The student demonstrates practice which is significantly disruptive to the operation of the clinic, places patients at risk of injury and/or places the clinic and staff in a position of liability.

If a student receives an unsatisfactory grade on a clinical rotation for anything other than late submission of paperwork, the student will need to remediate the entire clinical experience prior to progressing to the next (more advanced) clinical experience or completing the program. Though the setting at the next clinical site may not be the same as the setting in which the Unsatisfactory grade was received, ultimately, the student will need to satisfactorily complete a clinical rotation in the same setting as the Unsatisfactory grade.

The following conditions may present grounds for an Incomplete (I) grade:

The student is unable to complete the clinical experience within the designated time frame due to, but not limited to unforeseen circumstances such as family death or lack of fitness for duty which may include injury, illness, and complicated pregnancy.

If a student receives an Incomplete (I) grade in a clinical experience the additional time must be completed in the same setting as the original. This period must be scheduled for no less than six weeks for Long Clinical Experience and no less than two weeks for return to the same clinical site and four weeks for a new clinical site in the case of the Short Clinical Experience in the DPT Program, The PTA Program requires the full six weeks in order to increase the potential for a satisfactory completion.

Standards for Satisfactory Completion of Clinical Experiences

Grade Determined by: The final grade for each Clinical Education Experience is determined by the Director of Clinical Education and the Clinical Education Committee (CEC), which is comprised of the core PTA program faculty members, Department DCE, and Midterm Faculty Reviewer. When there is a more difficult decision to be made the DPT Program Director and two DPT DCEs will be asked to join the committee.

The grade is determined from the following resources:

1. Clinical Performance Instrument (APTA CPI 3.0) – Clinical Instructor assessment and Student self-assessments.
2. Interviews by academic Midterm Faculty Reviewers with CI and the Student.
3. Other sources of information may include classroom performance evaluations, peer assessments, patient assessments, the Program's didactic course faculty, and SCCE.

Rating Scale – The rating scale reflects a continuum of 6 performance levels ranging from "Beginning Performance" to "Beyond Entry-Level Performance". The student's performance is formally evaluated during the midterm period and at the end of the experience using the CPI 3.0 rating scale.

The CPI 3.0 has 11 criteria – all of which should be addressed. However, clinical instructors are encouraged to provide ongoing feedback to the student on the student's progress to allow timely communication and intervention if needed.

Standards for passing are:
First Clinical Experience (PTA LCE I): The student should be at a minimum of Advanced Beginner Performance [2] on all criteria.

Second Clinical Experience (PTA LCE II): The student should be at a minimum of Advanced Intermediate Performance [4] on all criteria.

Third Clinical Experience (PTA LCE III): The student should be at a minimum of Entry-Level Performance [5] on all criteria.

Each student is expected to attempt to attain "Entry Level Performance" [6] as described by the APTA CPI 3.0 Rating Scale Anchors descriptors by the completion of the Final Experience.

Student Signature Page

By signing below, I acknowledge receipt of the Loma Linda University Department of Physical Therapy Policy and Procedure Manual for Clinical Education. I agree to follow the expectations and guidelines as outlined. I understand the policies and procedures presented in the handbook are subject to change. I further understand that this handbook does not replace or mollify the contents of the School of Allied Health Professions Catalog or the Student Handbook.

Print Name

_____

Signature

Date

_____ _____