RESPONSIBILITIES

Teaching:

The ultimate goal of the clinical process is for students to actively apply knowledge that is learned in the classroom to the therapeutic setting. As students progress through the levels of the training program, they are expected to move from teacher-focused learning to self-directed learning. At each level, and in every venue, whether it is the classroom or the clinic, the objective is for students to learn independence.

The classical educational model for progression towards independence is *Bloom's Taxonomy* (Bloom, 1984). In this model, levels (types) of learning are presented hierarchically, each one being dependent on successful accomplishment of the previous level (Click here).

The ability to move back and forth through these levels is critical if one is to be independent in making good clinical decisions. It is the responsibility of the CI to help students move towards mastery each of these levels.

Working within this framework, the CI evaluates the student clinician's level of performance and provides whatever assistance is needed to ensure student learning and quality patient/client care. The CI identifies the level of functioning of the student clinician, and develops a plan that will move the student clinician to a higher level.

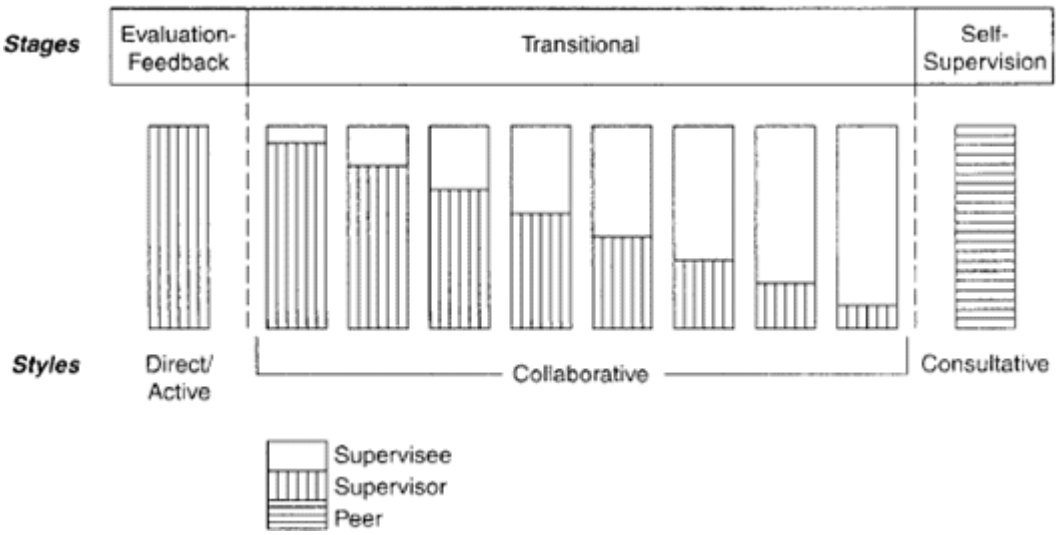
The procedure used by the CI is not unlike that used by clinicians in regards to the client. The process involves: systematic observation of the student clinician; identification of clinical skills that need development; and, provision of appropriate instruction, opportunity to practice, and immediate and accurate feedback.

Guiding:

Having a supervision style, and being able to vary the style according to the needs of the student clinician helps us apply a process that is beneficial to the client, to the student clinician, and to the CI. According to Anderson (1988), supervision exists on a continuum that spans a professional career. There are *styles of interaction* that are appropriate to each *stage* along the continuum (see page 12).

Anderson (1988) discussed three types of supervision, which, by their nature, require students to function at an increasingly higher level. The *Skills Tracking Forms* (see Calipso) reflect this concept of assessing the student clinician's stage of clinical performance and using an appropriate style of supervision that fosters growth towards independence. Some beginning clinicians will be able to function at higher levels, at least with some clients. Student clinicians should be encouraged to function at as high a level as possible, but not be expected to function at a higher level than their experience and knowledge can support. Clinical performance must always be assessed on a per

client/patient basis, so that false assumptions are not made about the student's stage of development and, therefore, about the appropriate style of supervision.



Stages and Styles of Clinical Supervision:

Stages:	***Characteristics:***
Evaluation - Feedback	The CI is dominant. Most beginning clinicians are at this stage, whether it is with a new type of client or new setting. In this stage, the student clinician is unprepared for clinical interaction, unable to problem solve, overwhelmed by the dynamics of the situation, or is used to being told what to do. The student clinician has a passive role. The goal for both the CI and the student clinician is to move out of this stage as quickly as possible.
Transitional	The student clinician has reached a level of moderate competency and knowledge, and. the CI has achieved an attitude that results in mutual participation. Joint problem solving and peer interaction occur. The student clinician is not yet able to operate independently, but is moving along the continuum, and is able to participate to varying degrees in decision-making. The student clinician is learning to analyze his/her own clinical actions, make modifications during clinical sessions, problem solve, collaborate within the supervisory conference, and plan future strategies. The CI is able to allow the student clinician to assume some responsibility. Interaction moves closer to peer interaction.
Self-Supervision	The student clinician is able to analyze accurately her/his own clinical behavior and to alter it, based on that analysis. The student clinician is independent in problem solving, no longer dependent upon the CI for observation, analysis, or direct feedback. It is still important to have peer interaction or consultation.

Styles:	***Characteristics:***
Direct-Active Style *(Appropriate for each Evaluation-Feedback Stage)*	The student clinician is passive, while the CI is in a controlling, directive position. The student clinician is functioning "within the box" (concerned about doing "it" the right way). This reflects what is commonly thought of as "traditional supervision," and is the style of choice for many clinical instructors. It is appropriate for some stages and some needs, but should be abandoned as soon as student clinicians are able to move towards independence.
Collaborative Style	This describes a more dynamic, problem solving, cooperative approach, wherein the CI and the student clinician work together to achieve optimum service for the client/patient, as well as for professional growth and development of both participants. The CI is less directive, but not inactive. Both assume responsibility, provide input, and jointly establish objectives for the client/patient and for the clinical experience. The CI provides feedback but also seeks input from the student clinician. The student clinician accepts responsibility for the client and for the supervisory process, and actively works towards independence.
Consultative Style	Self supervision for the student clinician. The student clinician bears the responsibility for the client's/patient's outcome, and for the outcome of the clinical experience. It requires a continuing search for professional growth through self-analysis. It suggests that there is now a peer relationship between the CI and the student clinician, and the CI can imagine the student clinician as an independent professional.

Assessment:

The ultimate responsibility of the CI is to help student clinicians identify existing strengths that will support the goal of becoming competent and employable professionals and to address those areas that will hinder their achievement of this goal. As part of this process, it is necessary for CIs to assess student clinicians' skills in many areas, and to base their evaluation on actual performance. It is not necessary to ensure that all skills are mastered in a single quarter; however, student clinicians in their final two quarters of the graduate program should be expected to be approaching mastery on most skills.

Supervision is not just observation. The term, "clinical instruction," is used purposely throughout this manual in order to reinforce the following principle: *clinical education is a developmental process that intrinsically depends on the participation of the clinical instructor in that process.*

Clinical education involves both formative and summative assessment. *Formative* assessment requires that the student clinician receive organized, continuous formal and informal feedback, opportunities for remediation, and documented progress towards accomplishment of skills. *Summative* assessment, on the other hand, is a summary of achievement, provided at the end of a specified unit of time.

DIRECT SUPERVISION

The Council for Clinical Certification/ ASHA requires that student clinicians be supervised by an individual who holds the Certificate of Clinical Competence in the appropriate area of practice. The amount of supervision must be appropriate to the student clinician's level of knowledge, experience, and competence. Supervision must be sufficient to ensure the welfare of the client/patient; however, direct supervision must be in **real time** and must be a **minimum of 25%** of the student clinician's total contact with the client/patient, and must take place periodically throughout the practicum.

DOCUMENTATION

The clinical placement of students is guided by the "rules and regulations" (standards) imposed by several accreditation and certification organizations. ASHA's Council on Academic Accreditation (CAA) and Council For Clinical Certification (CFCC) set standards for university programs (curriculum) and for the Certificate of Clinical Competence, respectively. The Committee for Teacher Credentialing (CTC) sets the standards for the California public school credential, and the Board of Examiners in Speech-Language Pathology and Audiology (SLPAB) sets the standards for licensure in the State of California. Loma Linda University strives to ensure that our students graduate having met the various standards for all these "governing" bodies. However, since each organization has its own standards (which sometimes do not overlap with each other), documentation may seem cumbersome. Clock hours reporting, skills tracking, observation reports, supervisory data, etc. are all important pieces of information, designed to demonstrate that the student clinician has met the criteria for the master's degree, ASHA

certification, the teaching credential, and the California license.

The student clinician is responsible for keeping track of the number of clock hours and all other data; however, clinical instructors are requested to carefully read each document in this document so that the clinical paperwork is complete and accurate. The clinical instructor will be asked to verify the student's submitted hours on Calipso.

SCHEDULING

Typically, students are placed in their clinical practicum for ten weeks, consistent with the academic quarter. The ten-week block may be modified, only with permission from the Director of Clinical Education, when circumstances require it. Such modifications are considered on a case-by-case basis and the Director of Clinical Education should be contacted if any changes are being considered.

During the educational fieldwork II and fieldwork II experiences, students are required to be on site a minimum of 10 weeks (equivalent to one quarter), fulltime. The goal is to achieve 120-150 face-to-face clock hours in assessment and treatment, as well as have a variety of experiences, achieving competencies noted on the skills tracking form.

The schedule of hours per day and days per week vary according to each placement. The student clinician and the clinical instructor should jointly arrange a schedule that is reasonable for both. If it does not appear that the student will be able to meet all of the goals for the quarter, the student clinician should inform the clinical coordinator immediately.

Vacations and planned time off should be arranged in advance. There are no unexcused absences. If the student is absent for more than **two days**, this constitutes excessive absences and the clinical instructor should notify the Director of Clinical Education. The student must make up unplanned missed time if the clinical instructor's schedule can accommodate.

A schedule, in the form of a weekly checklist is included on the website. While the student clinician is responsible for submitting the completed form to the Director of Clinical Education at the end of the quarter, the checklist can be modified as appropriate for each setting.