Clinic Practicum Procedural Manual

ERIN PAGE, M.S., CCC-SLP, CLINIC COORDINATOR
Table of Contents

WELCOME .......................................................................................................................... 4

1. CLINICAL DOCUMENTATION .......................................................................................... 6
   1a. Permanent Files ............................................................................................................. 6
   1b. Working Client Folders ................................................................................................. 7
   1c. Clinic Forms .................................................................................................................. 7
   1d. MOEC Clients ............................................................................................................... 10
   1e. SOAP Notes ................................................................................................................. 11
   1f. Clinic Reports ............................................................................................................... 13
   1g. Clarification on Semester Goals, Semester Objectives and Session Objectives .......... 14
   1h. Professional Writing Tips ............................................................................................. 15

2. GENERAL PROCEDURES ................................................................................................. 18
   2a. Scheduling Treatment and Diagnostic Sessions .............................................................. 18
   2b. Getting Started with Treatment Clients ....................................................................... 18
   2c. Clinic Attire ................................................................................................................... 19
   2d. Clinic Attendance ......................................................................................................... 19
   2e. Assigning Client Homework .......................................................................................... 20
   2f. Behavior Management Guidelines ............................................................................... 20
   2g. Observers ....................................................................................................................... 22
   2h. Audiological Screenings ............................................................................................... 22
   2i. Oral Mechanism Screenings ....................................................................................... 23
   2j. Diagnostic Procedures .................................................................................................. 24
   2k. Permanent File Set-Up Instructions .............................................................................. 28
   2l. Clean-Up After Sessions ............................................................................................... 29
   Appendix 2f-1. Audiometric Screening Procedures and Guidelines for Referral ............. 31
   Appendix 2f-2. Procedures for Portable Audiometer Use .................................................. 33
   Appendix 2f-3. Biological Calibration of Audiometers ........................................................ 34

3. CORRESPONDENCE .......................................................................................................... 35
   3a. Telephone ..................................................................................................................... 35
   3b. E-Mail ............................................................................................................................ 35
   3c. Mailboxes ....................................................................................................................... 35
3d. Mail for Clinic Purposes ........................................................................................................ 35
Appendix 3d-1. Sample Letter of Discontinuation .................................................................... 36

4. FACILITIES/MATERIALS ....................................................................................................... 37
4a. Lock-Up Procedures .................................................................................................................. 37
4b. Equipment or Computer Problems .......................................................................................... 37
4c. Clinic Waiting Room ................................................................................................................ 37
4d. Recording Sessions .................................................................................................................. 37
4e. Assessment and Treatment Materials ...................................................................................... 37
4f. iPads for Treatment .................................................................................................................. 38
4g. Access to Clinic Computer Lab After Business Hours ............................................................. 38
4h. Flipboards and Telepractice .................................................................................................... 39
Appendix 4a-1. UW Clinic Lockup Checklist .............................................................................. 40

5. GRADING & ASHA CLOCK HOURS ....................................................................................... 41
5a. Clock Hour Requirements ....................................................................................................... 41
5b. The Supervision Process ......................................................................................................... 42
5c. Supervision Requirements ..................................................................................................... 43
5d. Feedback ................................................................................................................................ 43
5e. Personal Goal-Setting and Self-Reflection .............................................................................. 44
5f. Grading/Conferences .............................................................................................................. 44
Appendix 5f-1. CALIPSO Student Performance Evaluations ..................................................... 46

6. CLINIC SAFETY POLICIES AND PROCEDURES ............................................................. 47
6a. Equipment ............................................................................................................................... 47
6b. Hand Washing ........................................................................................................................ 47
6c. Gloves ...................................................................................................................................... 47
6d. Spills ....................................................................................................................................... 48
6e. Human Blood Borne Pathogen Exposure Incident Instructions ........................................ 48
6f. Cleaning Solutions .................................................................................................................. 48
6g. Universal Precautions ............................................................................................................. 49
6h. Hepatitis B Vaccine ................................................................................................................ 50
6i. Health Insurance ..................................................................................................................... 50
6j. Liability Insurance .................................................................................................................. 50
7. EXTERNAL CLINICAL PLACEMENTS

6k. Emergency Response Procedure.................................................................................................................. 51

7a. Process of Securing an Externship .................................................................................................................. 52
7b. Externship Guidelines ..................................................................................................................................... 53
7c. Supervisor Requirements ................................................................................................................................. 54
7d. Student-Externship Supervisor Communication ............................................................................................. 55
7e. Student Expectations for Externships...Being a Student and a Professional .................................................. 55
7f. Supervisor Expectations for Externships .......................................................................................................... 56
WE ARE GLAD YOU ARE JOINING OUR GRADUATE PROGRAM, AND THAT SOON YOU WILL BE JOINING US IN THE RANKS OF CCC-SLPS. THE Cs STAND FOR CERTIFICATE OF CLINICAL COMPETENCE, AND ARE OFTEN REFERRED TO AS “Cs.” YOUR Cs WILL BE GRANTED BY THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION, THE ONLY ACCREDITING BODY FOR SLPs. THE Cs ARE ALSO OFTEN REFERRED TO AS YOUR “ASHA CERTIFICATION.”

SO YOU KNOW WHAT TO EXPECT, HERE IS A BRIEF OVERVIEW OF THE ASHA REQUIREMENTS FOR CERTIFICATION, WHICH WILL ALSO GIVE YOU AN OVERVIEW OF THE PROGRAM. FOR SUCCESSFUL COMPLETION OF AN ACCREDITED SLP GRADUATE PROGRAM (WE ARE ACCREDITED ☑️) 2 MAJOR ASPECTS ARE REQUIRED:

1) GRADUATE COURSES
2) CLINICAL EXPERIENCES (INCLUDING THOSE AT OUR ON-SITE CLINIC, AND THOSE EXPERIENCES OFF-SITE THAT WE COORDINATE FOR YOU)

ASHA HAS CERTAIN STIPULATIONS ABOUT THESE EXPERIENCES:

- The student must have obtained a sufficient variety of supervised clinical experiences in different work settings and with different populations so that he or she can demonstrate skills across the ASHA Scope of Practice in Speech-Language Pathology. Clinical experience (e.g., assessment, diagnosis, evaluation, screening, treatment, report writing, family/client consultation and/or counseling) should allow students to:
  - interpret, integrate, and synthesize core concepts and knowledge;
  - demonstrate appropriate professional and clinical skills; and
  - incorporate critical thinking and decision-making skills while engaged in identification, evaluation, diagnosis, planning, implementation, and/or intervention

- Successful completion of clinical experiences sufficient in breadth and depth must cover the following aspects: (These are the 3 overarching areas on which you will be scored in Calipso in order to receive satisfactory/unsatisfactory status for each semester of clinical practicum)
  - Evaluation Skills
  - Treatment Skills
  - Professional Practice, Interaction and Personal Qualities (e.g., clinical reasoning, oral and written communication, use of evidence-based practice, adherence to privacy policies, clinic procedures and ASHA Code of Ethics, etc.)

DURING YOUR GRADUATE PROGRAM, YOUR CLINICAL PRACTICUM WILL INCLUDE:

- 2 SEMESTERS OF ON-SITE SPPA 5030 AT THE UNIVERSITY OF WYOMING SPEECH AND HEARING CLINIC (UWSHC)
  - You will attend mandatory weekly meetings on Wednesdays from 8:00-8:50am during which you will learn about evaluation and treatment principles, clinical documentation requirements, clinic policies and procedures, etc.
  - You will provide on-going treatment for at least one, but no more than three, clients(s) throughout the fall and spring semester of your first year of grad school.
  - Your clients will change each semester so that you can get hands-on experience with a wider variety of disorders and age ranges
  - You will participate in at least one, but no more than two, diagnostic evaluation(s).

- 1 SEMESTER OF OFF-SITE SPPA 5030: COMMUNITY PLACEMENTS
You will go to your off-site location (most likely either a medical setting or public school) 2 days a week for approximately 12 weeks.

- During those 2 days, you will work the same hours as your supervisor.
- You will participate in ‘real world’ evaluations, screenings, treatment, meetings, conferences, etc.

- **Offsite SPPA 5270 & Off-site SPPA 5290**
  - The externships are viewed as an extension of academic and clinical experiences. Clinical instruction continues in these experiences. A student’s academic and clinical performance may be shared with external supervisors to enable them to best support the student’s learning.
  - Graduate students complete two full-time, twelve-week externships following completion of coursework and SPPA 5030 requirements.
  - Students register for one externship in the Spring and one in the Summer semester, but the beginning and ending dates do not align with semesters.
  - One externship is to occur in an educational setting (a school or early childhood program), and one is to occur in a medical or clinical setting. Most students will complete the educational internship first.

The remainder of this manual explains the requirements and procedures to complete the Clinical Experiences aspect of this graduate program. Further information about this appears in the SPPA 5030 Syllabus and the Graduate Handbook. It is not expected that you memorize the information in this handbook, or that you use it as the sole source of information for how to complete your Clinic Practicum duties. Rather, it is meant to be a resource that is available to you at all times. You are always encouraged to ask questions and seek supervisor guidance.

Again, we are so excited you chose our program, and we wish you success as you pursue a fulfilling career as a Speech Language Pathologist!
The Clinic Coordinator, Erin Page, will determine all clinical assignments. Client assignments are generally given at the start of each semester; diagnostic assignments are given throughout the semester. Please refer to the SPPA 5030 syllabus for information concerning the specific timelines for written assignments, conferences and grading.

Please note that all forms and documents that are referred to throughout this manual can be found in the SPPA 5030 WyoCourse website.

1. CLINICAL DOCUMENTATION
1a. Permanent Files
The clients’ permanent files contain the most current paperwork that we have received about our clients (e.g., IEPs, referrals, medical diagnoses, etc.) either from the client themselves or from an outside service/medical provider. They also include the documentation from our clinic (e.g., Contact Logs, SOAP notes, Evaluation Report, STP, Progress Reports, Permission forms, HIPAA forms, etc.). You will place original documents that you complete throughout the semester into the file when completed, approved, and signed by your supervisor. Additional information such as client work samples, homework, notes to parents, etc., is also kept in the permanent file and should be appropriately dated (i.e., month/day/year).

Permanent files should be signed in and out of the Clinic front office on the Permanent File Sign-Out Sheet in the Service Log Book, and an ‘out’ card should be placed in the spot from which the file was removed. Do not remove items from the permanent file; always keep the file together as a whole unit.

In accordance with federal law, the protection of the personal health information (PHI) contained within the files is paramount at all times. If you are unable to return a file to the file room, the file should be secured in a locked location (e.g., your locker in room 429 or in your accordion file in room 170) until it can be returned to the front office. No other locations are acceptable for permanent file storage. If you must leave a permanent file in room 170 to leave for class or while no one else is in the room, then you must lock the room. Students, not the clinic manager, are responsible for returning the files to the correct location and removing the ‘out’ card. Students must notify a supervisor in advance to obtain permission to keep a permanent file out overnight. Once permission has been obtained, you must keep it locked in your locker in room 429 or in your accordion file in room 170.

Permanent files never leave the Clinic premises unless the files are being transported to your supervisor’s office for a meeting or being taken to your locker in room 429 to secure overnight (with your supervisor’s permission). These are confidential documents and should be treated with great care. Do not shred anything from permanent files unless advised by your supervisor. Do not photocopy any of the information, but instead take notes using the Permanent File Summary form or your own preferred note-taking system.

Violation of these procedures is a violation of confidentiality as stated in the Graduate Handbook and may result in a failure of SPPA 5030 for the semester.
Archived files for clients who are no longer receiving treatment at the Clinic are kept behind the middle section of the file cabinets.

When setting up for a new client, the Clinic Office Associate, Diane Heien, will label the outside of the permanent file after receiving basic demographic information from the clinician. The inside of the permanent file will be labeled by the clinician. Sheets of labels are kept in the sample permanent file folders located in the Clinic Lab (room 170). If more labels are needed, inform the Clinic Office Associate. There are sample permanent files (2 green and 1 red) in room 170. More detailed instructions for how to set up permanent files for new clients can be found in the Diagnostic Procedures section (2h) of this manual.

1b. Working Client Folders
You will have a working folder (manila colored) for each of your assigned clients. You will be given this folder by the Clinic Coordinator when you are assigned your client. Working folders are kept in room 170 in a file drawer. Each clinician has her/his own file folder labeled with his/her last name. This is where you will keep all of your clients’ working folders (labeled with client initials) when not in a session. During your session, the client’s working folder should be in the observation room so that your supervisor and observers can view it. Working folders are turned in to your supervisor at the end of each semester.

Working folders should always contain SOAP notes from the 2 most recent sessions. Sessions that were cancelled do not count towards the 2, so you may have more than 2 SOAPs in the folder if there were missed sessions in between. The folder may also contain current work samples/word lists/reading passages. Please place copies of reading material and worksheets that you plan to use in the session in the working folder so that your supervisor can follow along. Clients’ working folders should not have any identifying information inside them (identifying information includes phone numbers). This means that the folder itself should only have the client’s initials on the outside. Clients’ complete names will not be used on written documentation until it is ready to be placed in the permanent file. That means that the top portion of a SOAP note (including the goals and objectives) will only have the client’s initials until 2 subsequent sessions have occurred and it is ready to be cycled out and placed in the permanent file. At that time, the clinician should complete the client’s full name. For example:

Clinical treatment note format for the working folder

Name T_________ S____________

When the note is placed into the permanent file

Name T rinity S andoval

Make sure the goals and objectives include only the client’s initials instead of their first name if you copy and paste from the STP.

1c. Clinic Forms (to be shared with/signed by client)
All UW Clinic forms are available in the SPPA 5030 WyoCourse under the appropriate module (either the Treatment or Diagnostic module). A list of the forms and a summary of each form’s purpose follows:

- Notice of Privacy Practices
This form should be reviewed with the client or client’s representative (e.g., parent) each semester and a copy offered for them to keep/read.

- It explains to the client how/when/why we may use their personal health information (PHI) and the Clinic’s policies and procedures for how we keep their PHI safe, secure and private.
- The complete Notice of Privacy Practices can be found in a binder in the Clinic waiting room (on the shelf next to the front desk) and on the Com Dis website under the UW Clinic tab (clinicians also have access to it in the SPPA WyoCourse website).
- Clients are to receive a hard copy if they wish and be informed of where they may obtain one electronically.

**Patient Acknowledgement Receipt of Notice of Privacy Practice**

- The client or client’s representative (e.g., parent) signs this form to indicate that they have been informed of the Clinic’s privacy practices, and that they were offered a hard copy of them to keep.
- A new form is signed annually. If the form was signed at the start of the previous semester, then the client needs only to initial and date next to their original signature at the start of the current semester.

**Treatment Agreement**

- This form is completed every semester and is signed by the clinician, supervisor and client/parent for all Clinic treatment clients.
- It is the financial agreement between the UW Clinic and the client/parent to pay for the services provided.
- Use the current SLP Fee Schedule to complete the ‘charge per semester’ and ‘fee schedule level’ fields on the form.
  - The number of members in the client’s household and the annual household income determine the fee schedule level (level 1=full price; level 2= half price; level 3= free services).
  - If the client qualifies for level 2 or 3, they must submit proof of their annual household income (e.g., federal tax return forms, social security statements, etc.) within the first month of services.
  - The client must also present their insurance, Medicaid or Medicare card(s) to the Office Associate, Diane Heien, so that a copy can be retained in their permanent file.
  - If the client qualifies for levels 1 or 2 and will be billing MediCARE, notify Ms. Page immediately. MediCARE requires different documentation and supervision procedures.
- Discuss any questions you have about billing with your supervisor before you present the form to clients.
- Once signed by all parties and a copy is made for the client to keep, the supervisor will give this form (the original) to the Office Associate, Diane Heien, so that she can update her billing records. Diane will place the form in the client’s permanent file when she is finished with it.

**Accent Modification Service Agreement**

- Complete this form instead of a Treatment Agreement if your client is receiving accent modification services.
- Accent modification services do not address a disability, and thus cannot be called ‘treatment.’
Follow the same procedures as for the Treatment Agreement form, except that the client does not need to present their insurance/Medicaid/Medicare card(s) to Diane. These must always be paid for by the client.

- **Permission to Evaluate or Treat**
  - This form is reviewed/initialed every semester and signed annually (or at the start of the diagnostic evaluation for a new client).
  - It serves as formal documentation that the client gives us permission to do what we see fit in order to provide them with treatment or evaluation services.
  - Offer a copy to clients.

- **Client Attendance Policy**
  - This form is completed and signed by the client/parent every semester.
  - The information outlines the expectations/procedures for participation in services provided by the UW Clinic.
  - Write on the form the known closure dates for the Clinic for that semester. The client/parent is given a copy of the form and the original is retained in the permanent file.

- **Permission to Audio/Video Tape and Take Photographs**
  - This form is reviewed/initialed every semester and signed annually.
  - For a diagnostic, this form is typically the first to be signed, allowing a full recording to be made of the evaluation.

- **Permission for Activities**
  - This form is reviewed/initialed every semester and signed annually.
  - There is a section labeled ‘Exceptions to above’ on this form. This is the place to note food allergies and any other restrictions the client may have.

- **Patient Authorization for Disclosure of Protected Health Information (PHI)**
  - If needed, this form is reviewed/initialed every semester and signed annually.
  - This form allows the UW Clinic to receive information from or disclose information to another entity.
  - You must fill out a separate form for each entity that the client wishes us to obtain information from or send information to.
  - A copy of this signed form should accompany all faxes sent and copies mailed to the entity designated on the form.
  - Each time information is sent or received, it should be noted in the last section of the form (or below, if there is no room left) and on the Contact Log in the permanent file.

- **Permission for Treatment Via Telepractice**
  - If your client will be receiving treatment via telepractice, then they must fill out this form annually. If they signed it during the previous semester, then they can initial and date next to their signature.

- **CPT and ICD-10 Codes (a.k.a. “Green sheet”)**
  - This sheet is filled out once a week per client and serves as our billing sheet.
  - It is often referred to as the “green sheet” and should be printed on GREEN paper.
  - Fill it out for each client each week of treatment and place it in your supervisor’s slot in the permanent file room for them to sign.
  - Your supervisor signs it and gives it to the Office Associate, Diane Heien.
You will likely need help filling it out the first time, so don’t hesitate to ask. The ICD-10 coding guide is in the SPPA WyoCourse website (in the ‘Resources’ module) to assist you.

**UW Speech and Hearing Client Questionnaire**
- At the end of each semester or when the final evaluation report is mailed to the client (if they are not returning for treatment), the questionnaire should be given or mailed to the client/parent to complete.
- Attach a self-addressed stamped UW envelope and ask that the client/parent to supply us with constructive feedback about the clinical services they received.
- The form is intended to be confidential and anonymous but the client/parent has the option of submitting their name.

**Client Intention Letter**
- All clients are presented with this form about 2 weeks prior to the end of the semester.
- This form lets us know if they wish to return for continued services the following semester.
- Be sure to confer with your supervisor about whether or not continued services are recommended before presenting this form to your client.
- Clinicians complete the top portion and client/parents complete the bottom portion, including scheduling and contact preferences.
- Only the bottom portion is returned to the Clinic Coordinator, Erin Page.

**Case History Forms**
- There are various case history forms (choose the one that best fits your client’s disorder or primary complaint) that each new client will complete prior to their first diagnostic session.
- These forms are mailed to the client at least a week before the appointment.
- They will either complete it and mail it back to us, or you can complete it in the format of an interview during the session.
- These are filed in the red/green permanent file.
- More details about these forms can be found in the Diagnostic Procedures section (2h) of this manual.

**Evaluation Agreement**
- This form is to be completed at the start of the diagnostic evaluation for a new client.
- Follow the same guidelines outlined for the Treatment Agreement form above.

**Summary of Diagnostic Evaluation**
- This form will be completed at the end of an evaluation to outline our initial impressions and recommendations.
- A copy will be given to the client at the end of the evaluation.
- See the Diagnostic Procedures section (2h) of this manual for more details.

Prior to the session, clinicians should complete known information on all forms before the client signs to make it faster and easier for the client. Do not leave blanks spaces on the forms (if needed, either put a dash or “N/A”). A client must not sign a form until all information has been filled in. Your supervisor will be in the room with you while all forms are being presented and signed to ensure that they are all completed thoroughly and correctly. With the exception of the Treatment/Evaluation Agreement form, you will place the original of all other forms in the client’s permanent file once completed.

**1d. MOEC Clients**
These clients are middle or high school students from the Mae Olson Education Center (MOEC). They reside at the Cathedral Home for Children. Since MOEC does not have an SLP on staff, they have a contract
with our Clinic to provide SLP services to any student whose Individualized Education Program (IEP) includes such services. Since, in these instances, we are operating as a legally-bound IEP service provider (rather than as an at-will service provider as for all other clients), the paperwork for these clients will be slightly different. All of the above forms except for the Treatment/Evaluation Agreement, Attendance Policy and Patient Authorization for Disclosure of PHI still need to be completed for these clients within one week after initiating treatment. The forms will be sent to Sara Settle (Case Manager) at MOEC to sign/initial and send back. You will also complete a confidentiality form for Ms. Settle to keep in the client’s file. If you have an MOEC client, your supervisor will advise you on following the appropriate report formats and timelines. The confidentiality form and report formats for MOEC clients can be found in the ‘MOEC’ module in WyoCourse.

1e. SOAP Notes

A SOAP note serves as documentation of when/how long the session took place, what occurred during the session, and how the client performed. It can be used as legal proof that appropriate services were rendered, and as evidence of skill progress or maintenance for third-party payers (e.g., Medicare, private insurance, etc.). Remember: if you didn’t document it, then it didn’t occur. Always write the note immediately following your session when things are freshest in your mind.

The most important things to remember in taking data is that you get something on paper first (it helps to always have a data-taking sheet prepared ahead of time), have it make sense to you, and analyze it immediately following your session. Ask yourself these questions: “What does the data tell me about my client’s performance today? What does the data mean when compared to last session? What factors do I think contributed to my client’s progress or lack thereof? How can it help me plan for my next session?”

Unless otherwise directed by your supervisor, data sheets you use during sessions can be discarded and do not need to be saved, turned in, or filed once you are done transferring the data to a SOAP note.

In addition to following the SOAP note template in the ‘Explanatory Templates’ module in the SPPA 5030 WyoCourse website, follow these tips:

- Sign the SOAP note using your complete signature. This includes name, degree and title (e.g., Katie Smith, B.S., GSC).
- Use the appropriate session codes (I=individual session; G=group session) in the left margin, and always put in the actual time that was spent with the client (e.g., if the client was 6 minutes late for their 30-minute session, then the time recorded in the SOAP note will be 24).
- In the S section, it is always better to describe a behavior rather than to label it. For example, instead of, “She was so stubborn today,” write, “Maggie refused to attempt any tasks presented by the clinician by declaring, “I don’t have to do what you say if I don’t want to!” The right word choices can get the same meaning across to the reader without being judgmental.
- Do not use white out in your treatment notes. These documents become part of the permanent record, which is a legal, confidential document. The proper way to correct a mistake is to make a single line through the error, initial it, and then write the correct word. This pertains to all clinical documents including treatment notes, contact logs, etc.
- An addendum can be added to a SOAP note if information was inadvertently left out of a preceding note. Write ‘Addendum’ next to the words ‘Clinical Note’ in the heading and then proceed with note as usual.
• Remember that good clinical writing skills take time to develop. It is an on-going learning process. Be open to suggestions and modifications.
• Remember that the S & O sections are a legal record of what actually occurred in the session. It should be completed immediately after the session.
• Refer to the additional general Professional Writing Tips (1h) at the end of this section of the manual.
• The following notations are acceptable for use in SOAP notes (but not in other formal clinical reports):

  DX  diagnosis
  TX  treatment
  Cln.  Clinician
  Clt.  Client
  D/C  Discharge or discontinue
  Info.  Information
  R/O  Rule out
  △  Change
  ▲  Increase or improve
  ▼  Decrease or worsen
  %ile  Percentile
  ɔ  with
  ɔ  without
  Lt  or L  left
  Rt  or R  right
  ○  No or none
  I  independently
  DNT  did not test
  Eval  evaluation
  c/o  concerned of or complains of
During your second semester, you will likely be prompted by your supervisor to practice completing SOAP note documentation *during* your session. This is intended to prepare you for working in a medical setting, in which documentation during sessions is necessary in order to fulfill productivity requirements. When practicing this, it is best to have a task prepared that the client will engage in (e.g., looking over and doing a couple of practice items on a homework assignment, reading an informational handout, tracking their own performance on a chart or graph, etc.) while you document. After you’re finished is a great natural opportunity to share your thoughts about the client’s performance and plan for next session with them.

**If. Clinic Reports**

Refer to the recommended textbooks for SPPA 5030 (see syllabus), a college handbook for proper English writing (e.g., *A Writer’s Reference* by Hacker), a dictionary, spelling and grammar-check, a computerized program such as Grammarly, etc. for tips on editing/proofreading all written work. For each of your clients each semester, you will write a Semester Treatment Plan, a Midterm Progress Note and a Final Progress Note. You will also write an Evaluation Report for each diagnostic evaluation in which you participate.

**Semester Treatment Plans (STPs)** are typically due within 3 business days after the last baselining session with your client (you will do 3 baselining sessions for most clients). Please defer to your supervisor for specific due dates and times. Follow the STP Explanatory Template in WyoCourse. The *original* STP is signed and placed into the permanent folder and a *copy* is given to the client/parent. An STP conference is held with the client/parent after the STP has been approved and signed by your supervisor. During the conference, you will provide the client/parent with a brief verbal explanation of the baseline date you gathered, the goals and objectives you want to target that semester, and the approach/general procedures you plan to implement. This STP conference is noted on the Face Sheet in the permanent folder.

**Midterm Progress Notes** are done approximately halfway through the semester, after about 6 and a half weeks of treatment. Please defer to your supervisor for specific due dates and times. If the client did not start treatment until the middle of the semester, then you will likely not write a Midterm Progress Note for them. Follow the Midterm Progress Note Explanatory Template in WyoCourse. Once the report has been approved and signed by your supervisor, you will hold a conference with the client/parent during which you will
verbally explain the most recent data that has been gathered and the client’s overall progress on their goals and objectives. You will also explain any recommended changes to the treatment plan, if needed. It is absolutely okay to change, discontinue, or add goals and objectives if the data you have gathered support it! If you state that a client has not made progress on a particular goal or objective (this definitely happens sometimes!), then you must offer a reasonable explanation and state what you plan to do about it. Give the client a copy of the report and place the original in the permanent file. The midterm progress conference will be documented on the Face Sheet in the permanent file.

Final Progress Notes are done at the end of the semester after the last treatment session. Please defer to your supervisor for specific due dates and times. Follow the Final Progress Note Explanatory Template in WyoCourse. Once the report has been approved and signed by the supervisor, mail a copy to the client along with a Client Questionnaire and a self-addressed return envelope. Place the original report in the permanent file. You must not leave campus until the Final Progress Note has been approved by your supervisor.

Please see the Written Product Feedback form in the ‘Supervisor Forms’ module in WyoCourse for how you will be graded on all clinic reports. Remember to send copies of all reports completed throughout the semester to any entity for whom the client/parent has signed an Authorization for Disclosure form. See the Diagnostic Procedures section (2h) for information about Diagnostic reports.

1g. Clarification on Semester Goals, Semester Objectives and Session Objectives

STP goals: Must include a time frame, (e.g., by the end of the semester), area of function to be improved (e.g., improve expressive language skills), skill (e.g., formulating complex sentences), condition (e.g., in an expository essay), criterion (e.g., % accuracy or % of opportunities; not % of the time), and degree of support (e.g., independently, with minimal support, etc.). For example: By the end of the semester, John will improve his expressive language skills by formulating complex sentences in expository essays with 90% accuracy and minimal support.

Semester objectives: These are the little steps, or prerequisite/component skills that will help the client perform the skill identified in the goal. They may be written vertically (i.e., the first objective must be met before the second objective can be targeted) or horizontally (i.e., all objectives can be targeted at the same time). They must include a skill and an accuracy and support level. The condition may or may not be stated in the objective, as it is likely that objectives will be practiced in many different conditions.

- Example of vertical objectives:
  - John will formulate an independent clause (i.e., a complete subject and predicate) with 90% accuracy independently.
  - John will formulate a dependent clause (i.e., an additional subject and predicate that adds a detail about when, why, etc.) to add to an independent clause with 90% accuracy independently.

- Example of horizontal objectives:
  - John will formulate complex sentences using the subordinating conjunction ‘whereas’ with 90% accuracy independently.
  - John will formulate complex sentences using the subordinating conjunction ‘although’ with 90% accuracy independently.
  - John will formulate complex sentences using the subordination conjunction ‘unless’ with 90% accuracy independently.
Session objectives: These are the logically sequenced, incremental steps that you hope to accomplish during one specific session. For example: John will complete the clinician’s independent clause by verbally adding a predicate with 90% accuracy and moderate support. This session objective would have followed after one of the earlier sessions where John was initially taught the necessary components of an independent clause.

1h. Professional Writing Tips
Below is a collection of tips for clinical writing compiled from ASHA recommendations and the input from previous and current supervisors. They are not written in a hierarchical form and should be used as a checklist as you evaluate your own writing. They are in no way comprehensive for all that is possible in clinical writing.

- Think/write CLEAR
  C = CLEAR
  L = LOGICAL
  E = EVIDENCE / ENOUGH
  A = ACCURATE
  R = RELEVANT

- Chronological age is marked by using a semi-colon (e.g., 13;7), not a colon. In narrative format, it is acceptable to write: Mary is a 13-year-old student or Mary is a 13 years, 7 months old student.

- Do not use contractions.

- Avoid referencing yourself, but if you must, do so in 3rd person, referring to yourself as ‘the clinician’ or ‘the examiner’. Never use personal pronouns (e.g., ‘I,’ ‘me,’ ‘we,’ ‘us’).

- Use a consistent format when referring to the client: either ‘the client’ or their name/initials but not both.

- Do not use indirect verbs to describe the client or their actions such as, “was able to,” “appeared to,” or “seemed to”. Instead, state what you directly observed (e.g., "John smiled" rather than, "John appeared to be happy" or “John wrote” instead of “John was able to write”).

- Do not use verbs that can’t be observed to describe what will be measured in client goals and objectives. For example, do not use verbs such as ‘understand,’ ‘comprehend,’ ‘recognize,’ ‘remember,’ etc. These are verbs that describe internal mental processes that you cannot observe or measure. Instead, state the verbal or nonverbal skill the client will demonstrate that gives direct evidence of their understanding, comprehension, recognition, or remembrance. For example, ‘Mr. Smith will answer questions about the anatomy and physiology of his voice production mechanism with 90% accuracy,’ is an observable skill that will tell you whether or not he understands the information. Here are some additional examples:

<table>
<thead>
<tr>
<th>Don’t say:</th>
<th>Instead say:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lilly will comprehend an expository passage with 90% accuracy.</td>
<td>Lilly will summarize the main idea and key details of an expository passage with 90% accuracy.</td>
</tr>
<tr>
<td>Ms. Carson will recognize familiar household items with 90% accuracy</td>
<td>Ms. Carson will name or point to familiar household items with 90% accuracy.</td>
</tr>
<tr>
<td>Ted will remember decoding strategies with 90% accuracy.</td>
<td>Ted will describe and demonstrate decoding strategies with 90% accuracy.</td>
</tr>
</tbody>
</table>
• Instead of referring to sounds with just this notation: /s/, use "the /s/ sound,” (e.g., Joey has been practicing improving his production of the /r/ sound). Delineate graphemes for spelling by other types of brackets (e.g., [r] or {r}).

• The first time you use a phonetic symbol in a document, you must include an example of it in a word. For example: Reagan correctly produces the /ʃ/ sound (e.g., as in “ship”) in the initial position of words with 89% accuracy.

• Always keep in mind the audience(s) to whom you are writing. Make sure the document can be understood by the client/parent, and is concise enough for a medical professional. Avoid extra, unnecessary wording. Use direct quotes when it is appropriate to clarify your statements about the client’s behavior, attitude, motivation or performance. Give examples to help clarify unfamiliar terms or procedures.

• Define all technical terms (e.g., phonological, grammatical morphemes, otoscopy, etc.) the first time they are used in each document. If you’ve defined a technical term in a previous document, you must define it again. Don’t burden your reader to have to go search for the other document to find out what the term means.

• Give the full name of an assessment first, immediately followed by the acronym. For example: Test of Problem Solving (TOPS). Then refer to the acronym from that point forward. The same applies for names of organizations, such as, American Speech and Hearing Association (ASHA). The name of an assessment does not need to be underlined, only capitalized

• Refer to a person as ‘who’ not ‘that’ (e.g., ‘He is a client who needs assistance’ as opposed to, ‘He is a client that needs assistance.’)

• You must address all supervisor comments/suggestions for revision in a draft. If you disagree with a suggestion, you must discuss it with the supervisor.

• Be certain of the spelling of client names, titles, and check all dates for accuracy.

• Watch verb tense switching throughout document. Keep tenses consistent within a section of the report (e.g., the progress report is written in past tense, since the semester/sessions have been completed).

• PROOFREAD by reading the report aloud to hear if the language used makes sense to you and a peer reviewer. You might try reading the report backwards as a way to check for spelling and punctuation errors. Allow time between the initial writing and proof-reading of the report. Make an editing checklist for problems you frequently encounter in your writing. If you struggle with the same elements consistently, your supervisor may assist you in devising a written checklist as part of an action plan.

• Beware your use of confusing/commonly misused terms. For example, effect (a noun) vs. affect (a verb).

• Use the abbreviations ‘i.e.’ and ‘e.g.’ correctly.
  o ‘i.e.’ tells your reader that you are going to explain or re-state a term in other words. For example:
    Gretchen produced a complete independent clause (i.e., a clause that includes a subject and predicate) to describe what was happening on each page of the storybook.
  o ‘e.g.’ tells your reader that you are going to give a specific example of something. For example:
    Gretchen produced a complete independent clause (e.g., “The little kid is running to his mommy”) to describe what was happening on each page of the storybook.
- Other terminology recommendations:

<table>
<thead>
<tr>
<th>AVOID</th>
<th>USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHOWED</td>
<td>DEMONSTRATED, REVEALED, INDICATED</td>
</tr>
<tr>
<td>GIVEN</td>
<td>ADMINISTERED</td>
</tr>
<tr>
<td>WORKED ON</td>
<td>FOCUSED ON, TAUGHT, TARGETED, PRACTICED</td>
</tr>
<tr>
<td>PRONOUNCE (*this term is only acceptable for accent modification)</td>
<td>PRODUCE, STATE, SAY, ARTICULATE</td>
</tr>
<tr>
<td>IN ORDER TO</td>
<td>TO</td>
</tr>
<tr>
<td>AS WELL AS</td>
<td>AND</td>
</tr>
<tr>
<td>PLUS</td>
<td>AND</td>
</tr>
<tr>
<td>IS/WAS ABLE TO</td>
<td>PAST TENSE FORM OF VERB</td>
</tr>
<tr>
<td>ABILITIES</td>
<td>SKILLS</td>
</tr>
<tr>
<td>TEST</td>
<td>INSTRUMENT, ASSESSMENT, EVALUATION, MEASUREMENT</td>
</tr>
<tr>
<td>THERAPY</td>
<td>INTERVENTION, REMEDIATION, PROGRAMMING, TREATMENT, MANAGEMENT</td>
</tr>
<tr>
<td>DISFLUENCY</td>
<td>STUTTERING</td>
</tr>
</tbody>
</table>
2. GENERAL PROCEDURES

2a. Scheduling Treatment and Diagnostic Sessions

1) Meet with your supervisor before scheduling with the client so that your session time does not conflict with your supervisor's schedule.

2) Clients should not be scheduled before 8:00am or after 6:00pm.

3) After obtaining your supervisor’s available times, review your schedule and find the times that work for both of you, then contact the client or client’s parent/guardian.

4) Once you’ve confirmed a schedule with the client, reserve a treatment room for all weekly sessions by placing a magnet labeled with your client’s initials and session start and end time on the board in room 170 in the corresponding room/day/time slot.

5) Please notify your supervisor and Diane Heien immediately when your treatment schedule has been confirmed with the client. Let them know what room your sessions will be in. Also notify them of any schedule or room changes throughout the semester.

6) Clinicians are responsible for keeping the master magnetic board treatment room schedule, located in Rm 170, readable and current.

7) If your client does not respond to 3 attempts to contact them for scheduling, send them a verbal and written final notice. Leave them a voicemail message and send them an email stating that it is your final attempt and that they have 2 days to respond. For example, “This is _____ from the UW Speech and Hearing Clinic. I have been attempting to reach you about scheduling, but I have not heard back from you yet. This is my final attempt to contact you. If I do not hear back from you by 6:00 pm on _______(tell them the weekday and date 2 days from now), then we will give your spot to another client. You are welcome to call me at ________ or email me at __________________. Thanks, and have a pleasant day.”

2b. Getting Started with Treatment Clients

At the beginning of each semester, you will be assigned a caseload of at least 1, but no more than 3, clients. You will receive the client’s working folder with the last 2 SOAP notes from the previous semester, and will be informed of who your supervisor is for that client, and the clinician who worked with that client during the previous semester. Follow these steps to prepare for your first couple of sessions:

- Schedule the sessions with the client, supervisor and Diane (see steps in the previous section).
- Read the client’s permanent file. Do not remove or photocopy anything from the file, but take thorough notes instead.
- Schedule a time to meet with the previous clinician to discuss what they did, what worked/didn’t work, behavior management tips, established session routines, etc.
- Schedule an initial planning conference with the supervisor. Bring the client’s permanent file and working folder. Be prepared to present your ideas for treatment approaches, methods, goals and objectives.
- Review the list of treatment paperwork and gather all necessary forms. Know which forms need to be printed off from WyoCourse and signed anew, and which forms from the permanent file can be initialed. Don’t pull forms needing to initialed out of the file, but instead just bring the entire file with you to the first session.
- Based on the potential semester goals and objectives discussed with your supervisor during the initial planning conference, plan baseline tasks for the first 3 sessions. You might not need 3 full sessions for baselining, but you will probably need at least 2. Remember not to scaffold, prompt or cue during
baselining tasks. Baselining should tell you what the client’s current level of functioning is and what they can do independently. Plan and bring materials for more activities than you think you will need in a session. If you run out of things to do with a client, you cannot dismiss them from the session early. It will be up to you to figure out something to fill the time with.

- Prepare and bring data sheets with you to the session. Your data sheet should be well-organized (charts work well) with specific places to indicate the objective being targeted, whether the client’s response was correct or incorrect, and what level of support was needed to elicit a correct response (if no longer in the baselining phase).
- Call the client/parent/guarding the day before the first session to confirm the schedule.
- Immediately after each session (including cancellations), enter it into the service log book.
- As soon as possible after the session, write the SOAP note and place the 3rd oldest SOAP note in the client’s permanent file.
- Complete a ‘green sheet’ for each client every Friday and place it in your supervisor’s slot in the permanent file room.

2c. Clinic Attire
Clinicians must wear their UW name badge at all times when working in the Clinic and with clients at other facilities (e.g., at MOEC). See Ms. Page if you forgot your badge and she will give you a temporary one. It is appropriate to remove your badge when working with a client in a public area (e.g., Turtle Rock) to protect the client’s association with the Clinic. Clinicians should wear appropriate professional attire (e.g., no baseball caps, no sweatshirts or hoodies, no revealing clothing, etc.) for all sessions, including observations. Professional dress is required at all times in the clinic. No blue jeans.

2d. Clinic Attendance
Attendance in clinic is expected and mandatory. You may only cancel a session in the case of an emergency (e.g., you have become suddenly ill) or program-related scheduling conflict (e.g., you are attending Cleft Palate clinic with Dr. Jones). If one of these 2 conditions apply, you must follow these steps:
1. Call and discuss the matter with your supervisor. Do not notify the client or cancel the session until you have gotten your supervisor’s approval.
2. You are responsible for finding a substitute clinician, planning the session, and making sure the substitute is prepared (e.g., materials, routines, instructions for tasks, data sheets, etc.) and that the client has been notified of the change in advance.
3. If unable to reach a supervisor in the event of an extreme emergency, contact the clinic (766-6426) and inform the Office Associate about your absence. Establish who will notify the client and the supervisor (you or the Office Associate). If there is no time to arrange for a substitute and it is very short notice for the client, the supervisor will conduct the session.
4. The substitute clinician is responsible for completing a SOAP note, making the service log entry, and submitting their own clock hour documentation in CALIPSO (this should be sent to the supervisor assigned for the client).
5. If a substitute is not feasible and the session had to be canceled altogether, attempt to re-schedule the session later in the week with supervisor consent.
6. Document cancellation and/or re-scheduling of the session in the SOAP note and the service logbook.
If a client cancels a session:

- Inform your supervisor and Diane Heien immediately.
- Document the cancellation in the SOAP note and the service logbook.
- Talk to your supervisor about whether you can re-schedule the client.

2e. Assigning Client Homework

To facilitate carry-over and promote a sense of pride and ownership regarding speech/language activities, it is expected that clients will be regularly provided with outside practice opportunities (i.e., homework/home practice tasks). When presenting a homework assignment to a client, first give them verbal instructions on how to complete the assignment, then demonstrate the completion of one or two items and ask them to complete one or two items to ensure comprehension of instructions. The materials you send home should always include written instructions also. If the assignment is for a child or Ark client and the parent/guardian/caregiver was not present during the session, a letter to the parent/guardian/caregiver and a written explicit description and model of the assignments you want the client to complete, how to complete it, and when it is due will be necessary. Encouraging the client to be involved in deciding what to complete for homework provides a good review of what occurred in a particular session and gives you information on how well the client can replicate the assignment on his/her own. If you are unsure what is needed for your client in this area, visit with your supervisor.

2f. Behavior Management Guidelines

The suggestions below are designed to be a general guide for how to manage behavior problems that are encountered during sessions. Consult with your supervisor for specific suggestions that may facilitate optimal behavior from your client.

Behavior management consists of shaping appropriate client behavior by differentially reinforcing desired behaviors (e.g., verbal praise, stickers, tokens, etc.). Undesired behaviors may either be simply brought to the client’s attention or ignored altogether. Note that we do not condone punishing undesired behaviors. Suggestions for successful behavior management include:

- Use the first session to find out what motivates your client (e.g., what topics/activities they are interested in, what specific communication skills they want to learn, what reading material they prefer, etc.)
- Use interesting and age appropriate materials.
- Keep things simple. Elaborate materials (e.g., complicated games, crafts, etc.) may detract from treatment objectives and be over stimulating to the client.
- Be well organized. Prepare everything, including the room/environment, before the client begins treatment.
- Be prepared for more than you think you will need. Vary materials if necessary but do not feel compelled to use everything that you have prepared.
- Positive reinforcement is more powerful in shaping behavior than negative reinforcement. **Example:** “I like the way you are looking at me Billy. I can tell you are ready to work.” Instead of: “Billy, look at me and stop fooling around so we can get started.”
- Resist showing anger or losing your temper. It may frighten your client and/or make the client misbehave even further.
Be consistent. The client must know what to expect from each task or session. A visual schedule can be very useful for some clients. Clearly explain your expectation and do not have one set of “rules” one day and another set the next session. Consistency will also help to decrease power struggles.

Maintain a matter-of-fact attitude about accomplishing the session’s tasks. Example: “I’m sorry that you are feeling tired but this is our scheduled time to work, so let’s get to it!”

Offer as many choices as possible to give the client a sense of control. (e.g., “Do you want to practice the /l/ sound or the /s/ sound first today?”; if the client is playing with something distracting, ask, “where would you like to keep that until we’re finished” instead of just telling them to put it away.)

Tell them how many items they have to complete before they receive a pre-determined break or reward (chosen at the start of the session so that they know what they are working for that day).

Keep the client’s attention. Some ways to refocus a client are to whisper, touch on the shoulder or arm, or silence while looking at the client.

When a client is demonstrating undesired behavior, remind them of the expectations and rewards and then quickly move on to the task planned.

Follow through with the reward plan. Make sure you never run out of time before the client receives the reward. If they don’t complete the task, let them know that they can try again next session.

Keep the client’s welfare paramount. This may mean keeping the client safe from harm by terminating a given task or the session entirely.

If a client becomes physically aggressive, distance yourself from them (perhaps even leaving the room) but continue to monitor them. You absolutely cannot leave an escalated client unattended. Do not attempt to physically restrain them or stop them from destroying materials. This is extremely unsafe for you and your client. Materials can be replaced. Wait until your client is calm before attempting any interactions with them.

Additional strategies to use with individual young children and in groups:

1. **In giving directions:** Be sure the child understands. Get to the child’s level when you give a directive; both in your choice of words and physically (stoop down).

2. **Be matter-of-fact:** Take compliance for granted, -- “We all do this.”

3. **Be quiet in manner and tone:** Move slowly, talk softly, be in the background as much as possible.

4. **Let the child learn by experience:** Help him/her only when it is necessary to avoid a feeling of failure or discouragement.

5. **Praise the type of behavior you wish continued:** It is better to emphasize the good things and let the bad drop out of sight. If you must attend to the bad behavior, attend to the behavior not the person (e.g., “Hitting is unsafe” instead of “You are not being nice”).

6. **Be consistent:** Praise or disapproval should be given consistently for a definite behavior.

7. **Suggest the next specific act when a child dawdles:** When a child continues with one activity for too long, say for instance, “Where is the lid to the box?” to terminate the activity.

8. **Give the child a choice of action when feasible:** Asking, “Where would you like to put your train, here or there?” gives the child a personal interest in the situation and develops his initiative and independence.

9. **Give the child a choice only when you can accept his negative reply:** Do not say, “Do you want to do X?” or “Can you do X?” State the expectation without asking.

10. **When children are in a social conflict situation, let them work it through if they can.** Step in to suggest a socially approved solution if the conflict continues for an extended period of time or if children begin to
show signs of escalation. You may need to terminate the task or remove them from each others’ company for a ‘cool down’ period.

13. **Don’t interrupt anything the child is doing without giving him a fair warning:** Prepare him/her in advance that, “After 2 more minutes/turns it will be time to pick up.” Setting a timer is useful.

15. **State what is expected instead of what is not expected:** Say, “Sit at the table with your juice, Mary.” Not, “Don’t blow bubbles in your juice and don’t spill.”

16. **Have confidence in yourself:** Children feel your uncertainty and act on it. A hurried decision is better than losing a child’s attention with uncertainty.

---

### 2g. Observers

Undergraduate students or other individuals will be observing treatment and diagnostic sessions pending approval from clients/parents/guardians. These students may ask you for client information to complete assignments. Please provide it to them in a timely manner, always remembering the **minimum necessary rule**. You may only share with them the client’s general communication diagnosis (e.g., vocal hyperfunction, articulation, aphasia, specific language impairment, Autism Spectrum Disorder, etc.) and information about treatment goals, objectives, prompting, scaffolding, behavior management strategies, etc. You may **NOT** share with them information about personal or medical history (e.g., specific circumstances leading to a brain injury, complicating factors such as drug/alcohol use, etc.). In short, if it’s in the SOAP note, you may discuss it. If not, sharing such information is a HIPAA violation. If an observer asks you for information that is outside of the minimum necessary rule, let them know that it is against the Clinic’s Privacy Practices for you to share such information.

Communication Disorders undergraduate students will also require you to sign their observation log. These students must wear their observer badges during the session to obtain credit for the observation. They must also be in compliance with clinic dress code (i.e., no blue jeans). If an observer does not have a badge or is not dressed appropriately, you should dismiss the observer from watching your session. Other outside observers (e.g., visiting SLP, grandparents, Ark staff, etc.) are allowed **pending approval from clients/family.** Family members, friends, or caregivers of clients do not have to comply with clinic dress code.

---

### 2h. Audiological Screenings

At UWSHC, we screen each client’s hearing once each semester, around midterm, unless there is an exceptional reason not to (e.g., the client has a known hearing loss and is already under the care of an ENT/audiologist). You must obtain supervisor approval if there is a legitimate reason not to screen your client’s hearing. Otherwise, use the sign-up sheet on the audiology suite door to schedule a day and time to perform a hearing screening for each of your clients. Notify your supervisor **at least 48 hours in advance** of when this is scheduled so that they can be sure to be there to give you feedback and scores. Supervisors will use a hearing screening observation checklist (see the Screenings Feedback form in the Supervisor Forms module in WyoCourse) to document and evaluate your performance. When practicing this procedure, you are encouraged to use the checklist to ensure that you are including all the necessary components of a well-rounded screening. These screenings are conducted in the audiology suite, preferably in one of the two sound booths with the booth door closed. If more than 2 clinicians are using the audiology suite at a time, it is acceptable to use one of the two outer stations. You and your supervisor can determine together whether you need assistance from an audiologist in exceptional situations or when OAEs are needed (e.g., your client has a cognitive impairment, has challenging behaviors, etc.). Contact...
the audiologist in advance for scheduling the screening if these conditions apply. Follow these steps for hearing screenings:

1. Practice on several members of your cohort several times prior to conducting client screenings.
2. Read Appendices 2f-1 through 2f-3: Audiometric Screening Procedures and Guidelines for Referral, Procedures for Portable Audiometer Use, and the Biological Calibration of Audiometers sheet.
3. If you have questions about procedures or equipment have them answered by a supervisor before you are scheduled to begin the screening. You must notify a supervisor if you notice equipment problems as you are practicing.
4. If a client has had a screening before, know the results of this prior screening and share them with your supervisor.
5. Prior to screening your client, make sure equipment is turned on, warmed-up for at least 10 minutes and functioning properly; then perform a biological calibration (see appendix 2f-3). Make sure the number on the headphones matches the number on the audiometer. Do not switch headphones and audiometers, as this disrupts calibration.
6. Make sure the otoscope is adequately charged or batteries are fresh. If they are not adequately charged, then plug them in the day before the screening and/or replace the batteries. Generally, otoscopes are kept plugged in to an outlet at their assigned station when not in use.
7. Conduct the hearing screening (see appendix 2f-1) and fill out the hearing screening protocol completely (in the Diagnostic Paperwork module in WyoCourse).
8. If the supervisor was not present during the screening, always consult with them about results before counseling clients or parents.
9. Turn off all equipment and otoscopes after the screening, unless someone has signed up directly after you.
10. Place used tympanometry tips in the container marked ‘dirty.’ Materials room staff will clean them later. Discard used otoscope tips.
11. The completed screening protocol is due to the supervisor within 24 hours.
12. Once you and your supervisor have signed the protocol, place the signed screening protocol in the client’s permanent file.
13. Hearing screenings are coded under hearing under the evaluation category on the CALIPSO clock hour form.

2i. Oral Mechanism Screenings
Perform an oral mechanism screening on your client each semester around midterm (these are usually done during the same session as the hearing screening). Notify your supervisor at least 48 hours in advance of when this is scheduled so that proper supervision is maintained. Supervisors will use an oral mechanism exam observation checklist (included in the Screenings Feedback form in the Supervisor Forms module in WyoCourse) to document and evaluate your performance. Use this checklist when practicing this procedure to ensure that you are including all the necessary steps. Follow these guidelines:

1. Practice on several members of your cohort several times prior to conducting client screenings.
2. Before the session, clean the table and gather all materials (e.g., unopened tongue depressor, penlight, nasal mirror, gloves, pen, alcohol wipes). Oral mechanism materials are found in room 185. Put on gloves and clean all reusable materials with alcohol wipes, then place the clean materials on a clean paper towel until they are ready to be used.
3. Put on fresh gloves and conduct the screening following the items on the Oral Mechanism Screening Protocol (in the Diagnostic Paperwork module in WyoCourse) and the checklist on the Screenings Feedback form. If at any time during the screening you touch any surfaces that hadn’t been cleaned immediately prior to the session, then you must change gloves.

4. After the session, complete the Oral Mechanism Screening Protocol and turn it in to your supervisor within 24 hours.

Examples of acceptable descriptive terminology for specific tasks:

- **Rhythm, speed and accuracy are judged to be inadequate as indicated by ________________.**
- **Results are consistent with a diagnosis of Parkinson’s disease with reduced strength and coordination noted in ________________.**
- **Structures are adequate but deviation noted in function of tongue on elevation which may impact speech production for sounds such as ________________.**
- **Additional key markings that are acceptable:**
  - NR = no response from client
  - WNA = client would not attempt

Examples of acceptable terminology in the Summary/Recommendations section at the bottom of the protocol:

- **Structures and functions are adequate for speech production.**
- **Functions consistent with last screening on xx/xx/xxxx indicating no further regression or loss of skills.**

If needed, write a recommendation such as:
- **Follow-up screening after palate expander has been removed to assess articulation.**
- **Re-screen next semester due to lack of compliance.**

5. Once you and your supervisor have signed the protocol, place it in the client’s permanent file.

6. Oral mech screenings are coded under **Artic** and under **evaluation** on the CALIPSO clock hour form.

7. You will be evaluated on your screening procedures and given feedback and scores from your supervisor using the Screenings Feedback form.

### 2j. Diagnostic Procedures

The Clinic Coordinator will assign all diagnostic evaluations. A team of two clinicians typically conducts diagnostic evaluations. Assignments will be emailed to the assigned clinicians and supervisor at least one week before the appointment. One clinician is designated as the ‘lead clinician’ and the other clinician is designated as the ‘partner’. The lead clinician is responsible for all communications with the supervisor and client, scheduling, and paperwork. Observers may also be assigned if a specific role for them to play is needed (e.g., assist with data taking or transcription). It is the goal of the Clinic Coordinator to assign every clinician as a lead and as a partner in at least one diagnostic each semester; however, there is no way to predict how many diagnostic evaluations we will have in a semester, or how many will cancel. Although it is the lead clinician’s responsibility for making sure the evaluation runs smoothly, it is up to all team members to work together for a successful outcome. Typically, the clinicians will be scored separately for their roles in conducting the diagnostic session (refer to the Evaluation Feedback form in the Supervisor Forms module in WyoCourse). The clinicians will complete the Evaluation Report (see the explanatory template in the Explanatory Templates...
module in WyoCourse) collaboratively, and one score for the report will be given to both clinicians. It is the supervisor’s discretion to adjust these scoring policies and at times, a clinician may be assigned a specific section of the report to write and be scored on separately. Below are the detailed steps for conducting a diagnostic evaluation:

- The lead clinician will schedule an initial planning meeting with the supervisor (the partner also attends this meeting). An informational sheet will be distributed to the lead clinician from the supervisor at the meeting.
  - The supervisor and diagnostic team will determine a convenient time for the diagnostic between 8:00am and 6:00pm on a Friday. Evaluations are scheduled for 2 hour blocks.
  - The team will discuss potential evaluation procedures.

- After the initial planning meeting and at least 3 days before the session, the lead clinician will turn in the Diagnostic Plan (in the Diagnostic Paperwork module in WyoCourse) to the supervisor for their approval. This plan will include what procedures will be included and which clinician will carry them out. (Note that an oral mechanism and hearing screening are typically included in any diagnostic session.)

- The lead clinician will contact the client/parent.
  - Establish the day and time for the session. Remind them that diagnostic sessions are scheduled on Fridays, since other days of the week are reserved for treatment. Remind them that the session will take approximately 2 hours.
  - Ask any follow-up questions that were brought up during the initial planning meeting.
  - Confirm their address and preferred contact information.
  - Discuss the fees and sliding scale.
  - Tell them you will be sending them a packet (described below) and let them know that it is preferred if they mail the case history form back to us before the session. If this is not feasible for them, they can bring the completed form with them to the session.
  - Discuss having observers, if applicable.
  - Tell them you will call them to confirm the appointment the day before the session.

- Mail out the diagnostic packet including:
  - Case history form (choose the most appropriate one from the Diagnostic Paperwork module in WyoCourse or create your own, with approval from your supervisor)
  - Self-addressed return envelope
  - Fee schedule
  - Campus map
  - Parking pass

- Set up a red permanent file (instructions for file set-up are in the next section). This folder must be kept in the permanent file room. All the same procedures for HIPAA compliance as discussed in section 1a apply.

- Document all contact with the client on a Contact Log form and complete a Face Sheet (both found in the Permanent File Forms module in WyoCourse).
  - The Contact Log is used with ALL clinic clients. This form is used to document all correspondence with clients/parents or others directly involved with client management, including evaluations. This includes documenting when information is received and sent by fax or by other means (e.g., e-mail,
phone calls made, copies of information delivered by client/parent). It also includes the dates of when STP/IEP conferences are held, etc.
  • Printed e-mail correspondence can be referenced in the contact log and placed underneath the contact log sheets, with the most recent on top.
  • This form is **not** used to document weekly meetings between supervisors and graduate students nor is it to record the events of an evaluation or treatment session.

• The **Face Sheet** documents the client’s biographical data and treatment/assessment history, including the graduate clinician’s name, and any meetings with client/parents (e.g., IEP, staffing, conferences, etc.) This information should be updated **each** semester.
  • Additional pages may be added, with the most current Face Sheet on top.
  • Never discard older Face Sheet documents.

• If the client mails back the case history from before the session, place the original in the permanent file and give a copy to the supervisor.
• Secure a room for the diagnostic. Place a temporary post-it note on the master schedule board in room 170 to indicate the day and time of the diagnostic.
• The lead clinician informs the supervisor and the Office Associate of the day, time, and location of the diagnostic once it is scheduled.
• You must review and **practice** all assessment materials and procedures **thoroughly** before administration! It is expected that standardized procedures will be followed, including application of basal and ceiling rules. Remember that scores are invalid if basal and ceiling rules are not followed **exactly** as described in the assessment’s manual.
• Assigned observers, if applicable, should be informed of what their role will be during the evaluation after the planning meeting.
• The client/parent should be contacted the day before the diagnostic to confirm the appointment. Remind the client/parent to bring the case history or other pertinent forms with them if they have not already mailed them back.
• On the day of the diagnostic, place copies of all forms and protocols in the observation room for the supervisor and observer (if applicable).
• Complete the diagnostic paperwork (see the List of Diagnostic Session Forms in the Diagnostic Paperwork module in WyoCourse) with the client or parent/guardian.
• Once the paperwork has been completed, parents should be encouraged to observe in the observation room and not remain in the diagnostic session unless they are needed due to separation anxiety or to be interviewed.
• As long as the patient signs the Permission to Video/Audio Tape and Take Photographs form, all evaluations should be video-recorded for later review and analysis. As soon as the paperwork is completed, start the recording. (Note that although the session is being recorded, clinicians are encouraged to take on-line data during the evaluation for immediate analysis and examples to present during the oral summary at the end of the session.)
• If the case history form was not completed beforehand, allow for sufficient time to complete it during the session in the form of an interview (i.e., you ask them the items on the case history form and any additional follow-up questions as needed).
When administering a standardized assessment, record the responses immediately and directly on the assessment protocol. (To protect the client’s PHI, do not complete the heading information until it is ready to be filed in the permanent file.)

At the end of the session, the supervisor and diagnostic team will meet in the observation room (the parent/caregiver will be sent to join the client in the treatment room) to discuss their findings and complete a Diagnostic Summary Sheet (in the Diagnostic Paperwork module in WyoCourse).

The lead clinician will return to the treatment room to give the client/parent/caregiver a verbal summary of results, findings and recommendations. A copy of the Summary of Diagnostic Evaluation sheet is given to the client/parent to take with them and the original is filed in the permanent folder.

Following the final summary, the clinicians should escort the client/parent back to the Clinic waiting room to complete any payment with the Office Associate based upon the Diagnostic Agreement form.

Both clinicians will collaboratively write the Evaluation Report, unless otherwise directed by the supervisor. This report is typically due within 3 business days of the diagnostic session. Your supervisor will give you a specific due date and time at the end of the session.

The lead clinician will submit the report to the supervisor via email by the due date and time. They will place all data recording sheets, language sample analyses, and completed assessment protocols and manuals in the supervisor’s mailbox at the same time they submit the report.

The supervisor will email the Written Product Feedback form (in the Supervisor Forms module in WyoCourse) with feedback and grades to both clinicians. They will return all data sheets, protocols, etc. back to the lead clinician. The lead clinician will file these in the red permanent file.

Once finalized and signed by the clinicians and supervisor, the original diagnostic report is retained in the red permanent file folder. A copy of the report is mailed by the lead clinician to the client/parent and others who are listed on the signed Permission for Disclosure form, if applicable.

Send a Client Questionnaire (in the Client Treatment Paperwork module in WyoCourse) with a self-addressed stamped envelope with the copy of the report that is sent to the client. Indicate in the Contact Log of the permanent file the date when the copy was mailed to the recipients.

If the client is returning for treatment, a copy of the evaluation report may be hand-delivered and discussed with them during the first treatment session instead of mailed.

If the client returns for treatment, the treating clinician will transfer everything in the red permanent file to a green permanent file.

General Information about Diagnostic Reports:

A diagnostic report is a systematic, written description of a client's overall communicative performance. In this report, the clinician states the assessment procedures administered and then describes the client's strengths, weaknesses, and present level of functioning. From this information, a diagnosis and recommendations are made. The report must stand on its own merit as often the clinician is not present to defend it. The written report is viewed in parts but must read as a whole unit. It must also convey enough information for the reader to understand as if they were present during the evaluation.

For some clients, you must evaluate all aspects of communication. For other clients, only selected aspects of communication need to be assessed. Make those sections that relate directly to the primary reason for the referral first and the most specific. Other sections can be more general.
In some instances, you will be asked to determine whether or not a communication disorder exists (e.g., articulation, language, dysphagia, etc.). In such cases, your information will: a) explain the nature, cause, and extent of the disorder, and b) serve as a foundation or support for your recommendations.

In other cases (e.g., stuttering, and aphasia) you and the client know that a disorder exists. Thus, your job is to describe the parameters of the disorder and target goals for treating the disorder.

In virtually all cases, your diagnostic information will be used as a baseline measurement of performance against which progress in treatment will be measured.

Clients, parents, educators, physicians, and other professionals read diagnostic reports. Thus, the report is a reflection of you, your supervisor, and the University's credibility. Therefore, accuracy of content and professionalism of wording is important!

When writing the report, refer to the client by name. Always use a title (Mr., Mrs., and Miss) when referring to an adult client unless otherwise indicated by your supervisor. Use the same format when referring to the parents of a child (e.g., Mrs. Smith, John’s mother, etc.)

VERIFY all assessment scores and be certain that all information on the assessment protocols (including name, birthdate, date of evaluation, scores, etc.) is correct. There are times when copies of the assessment protocols are requested with the report so information must be accurate.

Reports should be written with the primary audience in mind (i.e., client and parents), but should also included professional terminology for other SLPs, physicians, etc. Technical terminology (e.g., ‘phonation,’ ‘grammatical morphemes,’ ‘phonological processes,’ ‘executive functions,’ etc.) contained within the report should be supported with explanations and/or examples.

Sometimes a client is referred to our Clinic to seek an “objective second opinion”. In these instances, it is wise to make your observations more specific (by providing examples) and concrete since you are typically unable to support your findings in person.

See Evaluation Report Explanatory Template (appendix 2h-7) for specific guidelines and components of UWSHC’s Evaluation Reports.

2k. Permanent File Set-Up Instructions

- **RED DX file:** Red single divider folders are used for clients in the DX or SCREENING phase and will be set up by the lead DX clinician. All documents should follow a chronological progression with the most current information on top. There is a sample folder in the Clinic Lab (room 170) for reference. Once it is set up, it must be kept in the locked permanent file room at all times. The left side of the first section (inside front) should contain the following:
  - Acknowledgement of Receipt of NPP
  - Consent to Use/Disclose PHI forms
  - Permission forms

The right side of the first section (inside labeled as CONTACT LOG) should contain the following:
  - Contact Log
  - Insurance information (including sliding fee scale documentation)
  - Diagnostic Agreement form
  - Face Sheet
  - DX Intake Sheet

The left side of the second section (inside labeled as EVALUATION REPORT) should contain the following:
• Clinic Evaluation Report
• DX plan form
• Case history
• Assessment protocols

The **right side of the second section** (inside back) should contain the following:
- Information received from *outside* agencies (*not* to be copied for clients)
- MOEC evaluations, IEPs and school-based forms (*not* to be copied for clients)

**GREEN TX file**: If a client begins treatment following their DX evaluation, the treating clinician will transfer everything from the red file to a green file. The empty red file can be given to Ms. Page to recycle/reuse. **All documents should follow a chronological progression with the most current information on top.** There are sample folders in the front office and in the Clinic Lab (room 170) for reference. Once it is set up, the green file must be kept in the locked permanent file room at all times. The **left side of the first section** should contain the following:
- Acknowledgement of Receipt of NPP
- Consent to Use/Disclose PHI forms
- Permission forms
- Client Attendance Policy forms

The **right side of the first section** (labeled as **CONTACT LOG**) should contain the following:
- Contact Log
- Insurance information (including *sliding fee scale documentation*)
- Treatment Agreement forms
- Diagnostic Agreement forms
- Face Sheet
- DX Intake Sheet

The **left side of the second section** (labeled as **SOAP NOTES**) should contain only SOAP notes.

The **right side of the middle section** (labeled at **CLINIC REPORTS**) should contain the following:
- Progress notes
- Oral mech/hearing screening protocols
- Semester Treatment Plans
- Clinic Evaluation Reports (including DX plan form, case history, assessment protocols, etc.)

The **left side of the third section** (labeled as **WORK SAMPLES**) should contain the following (make sure each item includes the date it was completed/obtained):
- Work samples from treatment session activities
- Raw data sheets
- Language sample transcripts

The **right side of the third section** should contain the following:
- Information received from *outside* agencies (*not* to be copied for clients)
- MOEC evaluations, IEPs, school-based progress notes (*not* to be copied for client)

**2l. Clean-Up After Sessions**
The clinician is responsible for concluding treatment and diagnostic sessions on time. This includes cleaning and disinfecting the room. Another clinician may be scheduled for a session immediately following your
session, so please be conscientious and professional with your time management. As a general rule, you should begin to review and close your session about 2 minutes before the actual ending time. If your session starts late because the clinician before you continually ends late, please discuss this with him/her first. If the problem is not resolved, speak with your supervisor. Once the client has left, immediately return to the room to:

- Remove all materials and equipment from the room.
- Wipe down the table and chairs you were using with Lysol wipes or the bleach/water solution in spray bottles (these cleaning supplies are in the cupboards of each room).
- Wipe down all reusable materials/toys with Lysol wipes or the bleach/water solution before you reuse them or check them back in.
- Push chairs back under the tables.

Each clinician will donate 30 minutes to one hour during the last week of each semester to clean-up the Clinic areas, including the Clinic lab, treatment, observation and graduate rooms. The Clinic Coordinator will post a sign up sheet with a description of each job to be done the week before finals week. Supervisors will check on the status of this job at the final conference. All cleaning jobs must be completed before final grades will be posted.
APPENDIX 2f-1. Audiometric Screening Procedures and Guidelines for Referral

Once every semester (usually around midterm), you will complete a hearing screening for each of your clients. For most clients, the hearing screening consists of 3 parts: otoscopy, tympanometry and pure tone screening. If your client has **a known hearing loss and wears hearing aids**, you will complete otoscopy and tympanometry only—no pure tone screening. For clients with a known hearing loss, you must state in the ‘Recommendations’ section of the protocol that they should continue to see their audiologist regularly for ongoing monitoring and management.

**Otoscopy**

Visualize the external ear (skin tags/pits, malformed pinna, absence of a pinna, absence of an ear canal), ear canal (foreign body, blood, drainage, excessive wax, tube) and TM (perforation, tube placement, redness) and note any abnormalities. If things do not look normal, or you have questions about what you are observing, have your supervisor look.

Acceptable terminology:
- Otoscopy results are unremarkable.
- Otoscopy results show the ear canals to be clear.
- Otoscopy results show excessive cerumen (i.e., ear wax) that did not allow for a clear view of the tympanic membrane (i.e., ear drum).

Unacceptable terminology: Otoscopy is WNL.

**Tympanometry**

Complete a screening tympanogram on each ear. Typamometric width (TW) should be equal or less than 200 daPa to pass the screening (ASHA, 1997, p. 17). TW is sometimes referred to as a gradient (GR). Normal range for peak pressure (daPa) is +100 to -200, for admittance (cm3) it is 0.2 to 1.8. Ear canal volume (ECV) will vary greatly, but average ECV are .42 to .97 for children and .63 to 1.46 for adults. If you get a flat tympanogram, reposition the probe and repeat the screening or have your supervisor do it. Flat tympanograms must be interpreted in conjunction with ECV readings.

**Interpretation samples:**
- Flat tymp (NP, NP) with normal average ECV may suggest middle ear pathology (e.g., otitis media).
- Flat tymp with a small ECV may suggest that the ear canal is occluded with wax/debris (which would have been visualized in otoscopy) or that the immitance probe is pushed against the side of the ear canal.
- Flat tymp with large ECV suggests a patent pressure equalization tube (pe tube) or perforation of the tympanic membrane.

Acceptable terminology:
- Tympanometry results are within normal limits.
- Tympanometry results indicate negative middle ear pressure with normal admittance; (or if admittance is low) reduced admittance.
- Tympanometry results indicate flat tympanogram with normal ECV.
- Tympanometry results indicate flat tympanogram with large ECV, suggesting patent pe tube, perforated tympanic membrane (depending on what otoscopy revealed or patient/parents report). Otoscopy results are unremarkable.
Pure Tone Screening
Do not switch the headphones around with different audiometers. Each audiometer is calibrated to a specific set of headphones. Below are the procedures for children and adults.

Children
Pure tones are presented to each ear separately at 20 dB at the frequencies of 1000 Hz, 2000 Hz, and 4000 Hz. If you are screening in a sound booth, you can also screen at 500 Hz. To be considered a pass they must respond to all frequencies in both ears. For small children you may need to perform conditioned play audiometry. It is also important to vary the pure tone presentation rate to avoid the child from guessing.

Acceptable terminology: Passed/failed the hearing screening in the both/X ear at X frequency

Adults
Pure tones are presented to each ear separately at 25 dB at the frequencies of 1000 Hz, 2000 Hz, and 4000 Hz. If you are screening in a sound booth, you can also screen at 500 Hz.

Acceptable terminology: Passed/failed the hearing screening in the both/X ear at X frequency

Otoacoustic Emissions Test
If your client has challenging behaviors or a cognitive impairment and cannot complete the pure tone screening, you may perform an Otoacoustic Emissions test instead. Contact Ms. Garcia to discuss the use of Otoacoustic Emissions for your client.

Guidelines for Referral
- Red bulging TM - medical referral after consulting your supervisor
- Wax occluding ear canal, with flat tympanogram, and failing the pure tones at one or more frequency - medical referral after consulting your supervisor
- Foreign body in ear canal - medical referral after consulting your supervisor
- Tympanometric width (TW) or gradient (GR) > 200 daPa – rescreen in 3 to 5 weeks
- Flat tympanogram with normal looking ear canal and TM – rescreen in 3 to 5 weeks
- Negative middle ear pressure (beyond -200 daPa) – rescreen in 3 to 5 weeks
- Failure to respond to the pure tones at any frequency - rescreen in 3 to 5 weeks or at the discretion of your supervisor
- PE tubes: if the ECV is outside the normal range but with a flat peak (i.e., NP) and the tube is visible, the tube is likely working; if the ECV is within normal range with a normal peak and/or flat and tube is visible, the tube is likely not working.
- If you are unsure about the recommendation, consult your supervisor!
All of the portable audiometers (two GSI-38s and one GSI-39) are kept in the test room (HS182). These audiometers are used when conducting individual and/or group hearing screenings. The Audiology Clinic Coordinator will arrange the annual calibration of these audiometers.

- The power switch is located on the back of the audiometer.
- Before beginning a hearing screening, always perform a biological calibration. This means that the Clinician should check the operation of the immittance probe and both earphones at the frequencies to be assessed. Refer to Biological Calibration of Audiometers sheet. A copy of this sheet should be in each portable audiometer case. Notify the materials room manager if the biological calibration sheet is missing.
- The audiometer default is always set to begin with immittance testing. The probe lights indicate the following operation mode: flashing green = ready for testing; solid green = adequate seal obtained; yellow = occlusion; red = no seal obtained. Only use the button marked “tymp” for the immittance test not the button marked “tymp reflex”.
- Carefully return tympanometry probe to its protected sleeve during and after the tymp screening. It is a sensitive piece of equipment that should be handled with care.
- The Clinician should plot on the audiogram screening form (see form this section) the results of the immittance test. The following indicates the results of the immittance test and should be plotted on the audiogram:
  - ECV (physical volume) = ear canal volume; cm³ (admittance) = height of the peak; daPa = air pressure.
  - Clean the probe tips according to designated procedures.
- For audiometric screenings, the audiometer default is set to begin in the right ear at 1000 Hertz, 0 dBHL and with a steady tone.
- Use the dial knobs to make changes with the intensity and right/left ears. It is recommended to use a steady tone for all screenings.
- Perform the audiometric screening at 1000, 2000, and 4000 Hz at 20 dB (children) or 25dB (adults).
- Indicate the results on the audiogram form with a P = pass or F = fail and the hearing level tested.
- The GSI 38 Audiometer is capable of printing out results and has a memory to store up to eight screenings. Use the printing option only when the results are questionable and need to be evaluated by an audiology supervisor. Otherwise, record all data from the screening directly onto the audiogram form. A blinking M8 light will appear in the LCD display indicating that the memory is full and previous tests must be deleted/cleared to continue.
- Refer to the GSI-38 Quick Reference Guide (see form) for other operating instructions or consult an audiology supervisor.
- Notify either the AUD or SLP Clinic Coordinators in writing if supplies for the audiometer are low or the machine needs attention.
1. Check power.
2. Make sure the number on the headphones matches the number on the audiometer.
3. Check cords for signs of wearing and cracking, and listen to earphones while moving and twisting cords; check for signal intermittency when wires are twisted gently.
4. Check dials and switches for looseness or misalignment.
5. Check operation of interrupter switch/bar.
6. When tones are presented, listen for audible clicks or other sounds that might cue listener, both with and without earphones.
7. With attenuator set to audible level, change frequency on frequency selector. Listen to determine the presence of different and appropriate pitches; do this for both earphones. Listen for any hum, static, distortion (sound quality).
8. Do a rough check of linearity of attenuator by making sure that intensity/loudness is consistent with attenuator settings.
9. Listen for crosstalk between earphones; can disconnect earphone that is being fed a signal; listen to opposite earphone.
10. Check own thresholds or those of another person with known HLs, using both earphones. Levels should be within ± 10 dB of known thresholds.
3. CORRESPONDENCE

In general:

- Password protect all electronic client sensitive material. All supervisors have their own password for all documents sent to or from them. They will provide you with their password at the start of the semester to ensure protection when e-mailing confidential documents.
- Graduate students should only use the computers in the Clinic Lab (HS 170) or graduate room (429) for all client sensitive work (e.g., reports, SOAPs, or correspondence with identifying or sensitive information regarding your client).
- Computers in 170 and 429 are maintained by the Information Technology (IT) department. Problems with the computers should be reported immediately to the Clinic Office Associate (Diane Heien) or the Clinic Coordinator (Erin Page).
- Use a quality and reliable memory device (‘jump’/’flash’ drive) to save documents. Under no circumstances should client information be left on the hard drives of the computers.
- Every time you communicate with your client or with someone regarding your client outside the clinic, you need to log it in the Contact Log in the permanent file.

3a. Telephone confidentiality is important. Students may use the telephones in the Clinic, Clinic Lab, treatment rooms, and graduate room to make calls to clients. Long distance phone calls cannot be made from these rooms so it is appropriate to use the Clinic phone or a supervisor’s phone to make long distance calls (you may choose to use your cell phone if you wish). Properly identify yourself and your affiliation with the University of Wyoming Speech and Hearing Clinic. Leave only the minimum necessary information on voice mail for clients to return your call. Clients should return calls to the Clinic number (307-766-6426) unless the clinician chooses to give an alternate phone number (e.g., their personal cell phone number).

3b. E-Mail correspondence between a supervisor and graduate clinician OR client and graduate student should be kept confidential by only using initials when referencing the client and disclosing only the minimum necessary information. Again, password protection is required when sending private health information (including SOAPs and reports) or any document with the client’s full name. Consult the Graduate Handbook regarding violations of confidentiality.

3c. Mailboxes (HS 268) are used to exchange documents with client’s private health information or the client’s full name between clinicians and supervisors, but this should be used sparingly. It’s best to try and exchange such documents in person whenever possible. If mailboxes need to be used, documents should be placed into a large envelope and put in the supervisor’s mailbox. Do not place a document face-down in a supervisor’s mailbox without an envelope. Return delivery from supervisors to students will be handled in the same manner.

3d. Mail for clinic purposes is placed in either the wire mail basket in the clinic office area or on the shelf in room 268. Use the Clinic/Division envelopes for outgoing mail that is for clients. Place your last name above the return address label so that the document can be returned directly to you if needed. Please refer to Appendix 3d-1 for a Sample Letter of Discontinuation. This is a sample letter for dismissing a client due to lack of or poor attendance. Use the UW Clinic letterhead for the letter. It must be signed by the supervisor and Clinic Coordinator. A copy is retained in the client’s permanent file. Document in the Contact Log in the permanent file whenever anything is mailed to the client.
July 8, 2011

Dear Ms. XX,

In reviewing XX’s attendance record for the past year, she attended 50% of treatment sessions for this summer 2011, 92% attendance for spring 2011, 70% for fall 2010, and 71% for spring 2010. As per the Client Attendance Policy form which you signed, the UW Speech and Hearing Clinic requires clients to maintain a 90% attendance rate. For the past year, XX has met this requirement one out of 4 semesters. The 90% attendance requirement permits our students to provide the best treatment plus meet our clinic needs and responsibilities. Since this is a training facility, this attendance is important to allow our graduate clinicians the experiences and clinical hours in addition to providing consistent services to our clients.

Based on this lack of attendance and compliance with our policy, we will not continue to provide services to XX for the remainder of the summer semester and we are not recommending XX be placed on the fall clinic roster. We do recommend that you continue speech-language services at her elementary school.

Thank you for the opportunity to work with XX.

Sincerely,

Erin Page, M.S., CCC-SLP
Clinic Coordinator
4. FACILITIES/MATERIALS

4a. Lock-up Procedures
The clinician(s) who conduct the last treatment session of the day will complete a lock-up checklist (see Appendix 4a-1). Rooms within the clinic (e.g., 170, observation and treatment rooms) must be locked at the end of the day. The evening supervisor will do a final lockdown of the front, side and back doors to the clinic at 6:00pm.

4b. Equipment or Computer Problems
If there are any issues with any clinic materials, equipment, printers or computer, please do not attempt to fix them yourself or call IT. Notify either Ms. Page or Diane Heien so that we can contact the correct entity to come and fix the problem. We must keep a record of all services and repairs, so it is important that they go through the proper channels.

4c. Clinic Waiting Room
When you conclude a session, do NOT leave any client who is a minor unattended in the waiting room. If you have another client, either ask another clinician to assume the responsibility for this client, or notify your supervisor. Under no circumstances should you leave the client unattended or left with the Clinic Office Associate. If your client being picked up late is continually a problem, have a respectful conversation with the client/parent/guardian/transport person about this. If it persists, talk with your supervisor. Be aware that Ark clients may or may not be left alone in the community, depending on what is stated in their Individualized Plan of Care (IPC). Contact Ark if there is not a copy of the client’s IPC in the permanent file.

4d. Recording Sessions
The preferred method for recording treatment and diagnostic sessions is to use the computers in the observation rooms. Place your flash drive in the external port labeled ‘recorder.’ Wait for the name of your flash drive to appear in the external recording location field, and then hit record. After you’ve stopped the recording, you can watch it by plugging the flash drive in to the ‘player’ port. Be aware that recording cannot be password protected, and your flash drive now contains unsecured PHI. Watch your sessions and retrieve the data you need as soon as possible, then delete the recording. As long as your flash drive contains PHI, it should be treated as a permanent file and should not leave the clinic premises or should be kept in your locker in 429.

4e. Assessment and Treatment Materials
Once the first semester of clinic is well underway, the materials rooms will be unlocked during normal clinic hours so that you can conveniently check things in and out. This policy will change if materials are repeatedly not checked in or out correctly. If that occurs, we will implement restricted check-in/check-out hours.

Prior to checking out any clinic materials, you must complete a brief training and sign a completion of training form. This will be done during clinic orientation. Check-out of materials includes 2 steps: 1) record the item being checked out in the binder along with your name and date, 2) write down your name, date and item on an ‘OUT’ card and place it on the shelf/in the drawer where the item was located. You must not take any items out the door without properly checking it out first, even if you’re only going to use it in a session for a moment, and then ‘bring it right back.’ The rooms and materials that require these check-out procedures include:

- Room 182: Assessments and Screeners
Room 183: Speech/Language materials, flashcards, resource books, story books (an inventory of all speech/language materials/equipment/books has been compiled for your use and is located at the back of the check-out binder in this room)

Room 185: timers, sensory items, hot plate, therapy balls, analog clocks. (This room also includes cleaning supplies, oral mech supplies, Thick-it, and snacks that do not need to be checked out.)

These items do not have a check-out time limit, but please be conscientious of your fellow clinicians who may need to use the same item. You must check an item back in before another clinician checks it out and uses it.

To check any item back in (including sensory items and assessments), simply place the item in the baskets located in room 183 and write the date you returned it next to your check-out entry in the binder.

The person who has checked out an item is responsible for the item. It is not acceptable for one person to check out an item and then pass it off to another clinician without checking it back in first. An “incomplete” grade or other monetary consequences (i.e., you may have to reimburse the clinic for the dollar amount of the lost item or purchase a replacement item) may be imposed if material/equipment is not returned by the person recorded as having checked out the item.

Additional iPads for audio/video recording purposes only are kept at the clinic front desk. Please see the front desk associate (usually Diane Heien) to check one of these iPads out. To protect clients’ PHI, these iPads have a 24-hour checkout time limit. Retrieve the data you need from the recording as soon as possible after the session, then delete the recording and turn it back in. Clinic iPads must not leave the Clinic premises.

There are some additional general use materials that do not need to be checked in or out. These materials are found in observation rooms 169 and 175 and include:

- Room 169: toys, games, stickers, craft supplies, prizes, puzzles
- Room 175: figurines, toys for young children

From these 2 rooms only, simply take what you need and return the item (if applicable) when finished. Please notify Ms. Page if any non-checkout items are running low (e.g., stickers, craft supplies, snacks) or are in poor condition and need to be replaced (e.g., frequently used puzzles, toys, games).

4f. iPads for Treatment
The clinic owns 6 iPads equipped with speech, language and AAC apps that can be used for treatment throughout the semester. Each iPad will be assigned to ‘parent’ teams of 2 or 3 students. Those students will keep, share and use that iPad for treatment throughout the semester. AAC apps on these iPads can be individualized for the clients who will be using them that semester. The ‘parent’ team is responsible for charging and completing updates as needed. You cannot delete apps or purchase new apps on these iPads. Please see Ms. Page if a new app is needed. These iPads can be kept in 170 or 429, but cannot otherwise leave the building. If the iPad is lost or damaged, the clinicians to whom it is checked out will share the cost of replacing it.

4g. Access to Clinic Computer Lab After Business Hours
During the weeks when clinic is in session, the front, back and side doors to the clinic will be unlocked between 8:00am and 6:00pm. If you need to use the computer lab in the clinic (room 170) outside of these hours, you can
use your student ID card to enter through the front door. The door will automatically lock behind you, so make sure you bring your ID card with you if you need to leave for a moment and then return. Do **not** ever leave the clinic doors propped open, as there is very expensive equipment and PHI contained within.

**4h. Flipboards and Telepractice**

There is a permanent flipboard mounted to the wall in treatment room 173. This board can be used for in-person or telepractice sessions. There is a portable flipboard to be used for the same purposes in any of the other 3 treatment rooms. When not in use, it is to be kept in room 169. There is an additional telepractice station in room 249.

It is our hope that each clinician will get at least one telepractice client during their first year of clinical practicum. These sessions are held using Zoom. A hard-wired internet connection (via Ethernet cable) is required. Your supervisor will give you specific details about how to conduct telepractice sessions with your client.
**APPENDIX 4a-1.**

**UW Clinic Lockup Checklist**

Week of ____________ to ____________

Clinic Lockup checklist: this is the responsibility of the last clinician to leave the clinic for the day. If this is you, please initial next to each item:

<table>
<thead>
<tr>
<th></th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turn off all lights</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Push in all chairs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make sure space heaters are off and unplugged</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make sure perm file room is locked</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lock all observation rooms (supervisor will lock TX rooms)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make sure materials room is locked</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make sure cleaning room is locked</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make sure test room is locked</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make sure double doors (by clinic bathroom) are locked</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make sure clinic back door is pulled shut and locked</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make sure 170 is locked</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scramble 170 key combination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
GRADING & ASHA CLOCK HOURS

Earning clock hours requires three major aspects: 1) clock hours are supervised by a licensed and certified SLP (at least 25% of each client’s total treatment time must be supervised), 2) you record your hours and submit them for supervisor approval via Calipso, and 3) you pass your clinical practicum.

ASHA says, “Supervised practicum must include experience with client/patient populations across the life span and from culturally/linguistically diverse backgrounds. Practicum must include experience with client/patient populations with various types and severities of communication and/or related disorders, differences, and disabilities…The [student] must demonstrate direct client/patient clinical experiences in both assessment and intervention with both children and adults from the range of disorders and differences.” This means that we ensure you get diverse client experience while enrolled in our graduate program. To do this, we try to vary the types/ages of clients you see while you are completing on campus clinical hours and that we give you diverse off-campus experiences.

Your clock hours and clinic scores are managed in a system called CALIPSO. You will need to sign up for this service. How to register and use Calipso will be covered at clinic orientation.

5a. Clock Hour Requirements

ASHA requires 400 clock hours minimum for the Certification of Clinical Competence. This is also the minimum number required for graduation from our program. At least 25 hours must have been spent in clinical observation and at least 375 clock hours must have been spent in direct client/patient contact. 325 of those must be at the graduate level (you can claim up to 50 clock hours at the undergraduate level). Only direct contact with the client or the client's family in assessment, management, and/or counseling can be counted toward the practicum requirement.

The Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC) defines 1 clinical practicum hour as equal to 60 minutes. When counting clinical practicum hours for purposes of ASHA certification, experiences/sessions that total less than 60 minutes (e.g., 45 minutes or 50 minutes) cannot be rounded up to count as 1 hour.

While there are no minimum hour requirements in each of the different categories, every attempt is made to have at least some direct contact time listed in each of the big 9 categories for children and/or adults in treatment and/or evaluation with appropriate supervision.

- Hours must reflect the “breadth of the life span” and demonstrate multi-cultural aspects and severity levels.
- Hours should reflect direct services in prevention, screening, evaluation and treatment.
- “Big 9” disorder categories include:
  1. Articulation (this category includes accent modification)
  2. Fluency
  3. Voice and Resonance, including respiration and phonation
  4. Receptive and Expressive language (phonology, morphology, syntax, semantics, pragmatics, prelinguistic communication, and paralinguistic communication) in speaking, listening, reading, and writing
  5. Hearing (including impact on speech and language)
6. Swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding, orofacial myology)
7. Cognitive Aspects of Communication (attention, memory, sequencing, problem-solving, executive functioning)
8. Social Aspects of Communication (including challenging behavior, ineffective social skills, and lack of communication opportunities)
9. Augmentative and alternative communication modalities

All your clock hours must be logged into CALIPSO. These entries must be completed by **Friday at noon** for the week (unless you have a diagnostic session after noon on Friday; then just complete the clock hour entry by the end of the day). You may make an entry for each individual session, but it is preferred to make one entry for all sessions you had under a particular supervisor each week (by adding your session times together). For example, if you have an adult client and a child client both supervised by Ms. Sandoval, each seen 2 times a week for 30 minutes each session, the weekly entry you submit for her approval will include 60 minutes in the adult column and 60 minutes in the child column. Use the comment box at the bottom of the screen to list the dates of each session, the client initials and the number of minutes supervised out of total session minutes.

Take care to make sure you enter clock hours in the appropriate section (e.g., evaluation vs. treatment). Note that baselining activities, oral mechanism exams and hearing screenings are all entered in the evaluation section. Don’t worry if you realize you’ve made a mistake after you’ve submitted your entry. Let Ms. Page know and she can fix the entry for you.

IEP/STP/Progress conferences are part of treatment or the evaluation/screening category, depending on the nature of the information contained in the report. For example, if the STP you are discussing with your client includes interpretation of scores obtained during baselining activities, then this could be counted in the ‘evaluation’ category. Discussion of semester goals and treatment approaches would go under the ‘treatment’ category. Clinicians should strive to utilize all categories whenever possible. For example, if a client has more than one disorder, split the service time on your clock hour sheet accordingly e.g., 15 minutes in fluency and 15 minutes in articulation for a total of 30 minutes of treatment.

**5b. The Supervision Process**

The graduate clinician's major goal and responsibility in the clinical process is to provide quality service to their clients. This means planning effective assessments and treatment to the best of one's ability. It includes documentation, analysis and interpretation of collected data, and modifying treatment/recommendations as needed for the best possible outcome. In order to achieve this, the clinician should be an **active participant** in the supervision process. This includes critical reflection, self-evaluation of clinical skill/strengths/weaknesses and an on-going collaboration with the clinic supervisor. To be an active part of the supervision process, it is essential that the clinician openly expresses his/her thoughts, concerns, needs and ideas with their supervisor. It is best to go directly to your supervisor for clarification on expectations before consulting another supervisor or the Clinic Coordinator. To facilitate increased clinician independence throughout the semester, supervisor involvement should shift from a very hands-on teaching/coaching role at the beginning, to more of an as-needed collaborative role towards the end.
While you are enrolled in graduate school you will have many different supervisors who require or prefer procedures and documentation to be done in specific ways. This will differ between supervisors and may be confusing at times. Embrace these differences as a way to learn to do things many different ways, which contributes to your professional knowledge base as well as your ability to maintain flexibility as a clinician!

In your first two semesters you will have several (if not all!) supervisors that work here at the UWSHC. After that time, you will have supervisors at external placements (community placements and externships).

Please be aware that some supervisors may be more hands-on and take over parts of your session or speak to you during your session over an FM system, while others will quietly observe and never enter the treatment room. These different styles are based on many factors (e.g., the client’s needs/behavior, the supervisor’s relationship with the client, the supervisor’s clinical style, your relationship with the client, etc.). Do not make judgments about your own clinical performance based on the supervisory style (i.e., don’t assume that when your supervisor enters the room during a session you are not doing a good job; this is usually not the case!); rather, watch/read/listen and implement the feedback or follow the model you are given from your supervisor. If you are unsure about how you are doing clinically, set up a time to talk to your supervisor(s).

5c. Supervision Requirements
Supervision must be provided by individuals who hold the Certificate of Clinical Competence from ASHA. ASHA states that, “The amount of direct supervision must be commensurate with the student's knowledge, skills, and experience, must not be less than 25% of the student's total contact with each client/patient, and must take place periodically throughout the practicum. Supervision must be sufficient to ensure the welfare of the client/patient.” This means:

- that our supervision has to be in real time (not watching recordings of you after the session, though we can do that…it just doesn’t count as direct supervision time). This may take place in the room with you or from the observation room.
- supervisors must be available to consult with a student providing clinical services to the supervisor's client. In order to meet this ASHA requirement, we hold weekly group meetings, initial, midterm and final conferences, and are also available to meet with you individually (you just need to schedule a time or come to office hours).

5d. Feedback
Supervisors will provide written feedback about the clinician’s performance and may offer data or observations about the client’s performance. Electronic feedback is the most common way, but different supervisors may elect to give you feedback in different ways. The number of minutes supervised will be recorded on the feedback form and should be entered into the CALIPSO weekly clock hour form. The scores given on feedback forms correspond with the 5-point rating scale used in CALIPSO.

Your supervisors will all provide you with feedback about your clinical performance. At UWSHC, we provide you with more feedback than you will have at external placements. This is because you are new clinicians, but please note that this will be done differently by each supervisor. You may not receive feedback in the same way (e.g., email versus hardcopy), and you may not receive feedback on the same time schedule (e.g., every time they observe vs. weekly). We use feedback forms for our records to ensure that we are giving you enough
direction and/or information, and to ensure that you are implementing the feedback we give you. We also refer back to comments made in feedback forms when writing letters of recommendation.

5e. Personal Goal-Setting and Self-Reflection
In order to facilitate self-directed growth and learning as much as possible, you will be encouraged to set specific goals regarding your improvement of clinical skills. You supervisor(s) will ask you to informally submit at least one goal for yourself around midterm of first semester, and again at the beginning of second semester. These goals will not be ones you will be formally graded on, but will assist your supervisor in knowing what clinical skills to hone in on during their observation of you so that we can give you helpful and desired feedback and suggestions.

You are also strongly encouraged to engage in self-reflection after every session. This will take place informally during frequent conversations with your supervisor(s) (e.g., What went well during that session? What will you change for next time?, etc.). If needed, your supervisor may assign a more formal self-reflection assignment to be completed. You are also strongly encouraged to watch yourself during video-recorded sessions. This is a very useful way to critique your own skills and recognize areas for growth. This also may be used as a formal assignment as part of an action plan, if needed.

5f. Grading/Conferences (there is more detailed information about this in your SPPA 5030 Syllabus)
Students and supervisors will have regular conferences. This includes the initial planning, weekly, mid-term conference and final check-out. Prepare for all supervisory conferences by coming with ideas, potential solutions to problems, and self-reflections/self-evaluations. Adequate preparation demonstrates responsibility and initiative by the clinician. Come to the conferences with items to discuss and lead the discussion. Present ideas about areas upon which you would like to improve your clinical skills. Discuss some of the solutions to solve the problems you are encountering with your client or the overall clinic process.

You must be evaluated by all of your supervisors on your clinical skills with diagnostic and treatment procedures, documentation, professionalism, and adherence to policies, procedures, and the ASHA Code of Ethics (https://www.asha.org/Code-of-Ethics/). The criteria on which we evaluate you does not change and is determined by CALIPSO and ASHA standards. Our expectations on how well you meet these criteria over time does change. That is, we expect to see you grow in proficiency in all areas as you gain more and more clinical experience. Your grades in clinic are satisfactory/unsatisfactory, and is based upon whether or not you meet the minimum overall Calipso score for the semester (see the SPPA 5030 course syllabus).

Calipso scores range from 1-5 (see appendix 5f-1) and can be in increments of .25. Note that it is not at all unusual for clinicians to score in the 1.25 to 1.75 range during their first few weeks of clinic, so don’t be alarmed! That is totally expected! It is also not unusual for scores to fluctuate a bit from one week to the next. It is okay if your score one week is one or two increments lower than the week before. As long as your scores are on an overall upward slope throughout the semester, you have nothing to worry about. The only score that should cause you significant concern is a score of 1.0. This indicates that you are not doing something you definitely should know how to do at that specific point in time. This will be addressed via a formal action plan with your supervisor.
You will be evaluated formally in conferences at the midterm and final points of each semester by each supervisor to whom you are assigned until you graduate our program. This is done using the same CALIPSO form, which you can view anytime, using the same grading scale and criteria found on your session feedback forms. During the conference, you and your supervisor will compare scores, discuss your strengths and weaknesses, and will formulate goals and/or action plans as needed.

Recording your midterm evaluation is required; however, these are not permanently recorded. Only your final semester evaluations are used to determine a satisfactory/unsatisfactory grade for the semester. It is very possible for a student who is not passing at midterm to improve and pass at the final evaluation…it often just takes some focused work and good communication!

Your final conference will also include a checkout list completed by your supervisor. This checkout list ensures that all client documentation is completed correctly and placed appropriately in the permanent file; it also ensures that you have turned in materials, completed clean-up responsibilities, and not left personal items behind.

If a student fails a semester of SPPA 5030:

1) He/she cannot count the clinical hours for the semester (this is an ASHA stipulation).

2) He/she must comply with a remediation plan. An initial remediation plan is determined by any or all of the following individuals:
   - Clinical supervisor assigning the failing grade
   - Clinical supervisors also assigned to the student
   - Clinic Coordinator
   - Division Director
   - Graduate program Chair
   - Faculty or clinical supervisors with specific content knowledge regarding the client/case/disorder

3) He/she must repeat that semester of clinic.
All clinical courses with the prefix SPPA 5030, SPPA 5270 and SPPA 5290 use an S/U grading system. Each semester of the clinical courses has a separate cut-off to achieve either an S or U for mid-term and final grading (see the course syllabus for cut-off scores). The scale is graduated to reflect the increasing student expected performance (i.e., competency) over all clinical experiences.

CALIPSO GRADING:

1. **Skill not evident.** In the context of the student’s clinical experience and SLP training/education, the student does not demonstrate expected skills, despite a previous history of supervisor feedback. Supervisor must provide a maximal level of support via modeling, demonstration, direct instruction, etc. Student does not demonstrate awareness of behaviors needing to be addressed or attempts to resolve clinical problems.

2. **Skill is emerging.** In the context of the student’s clinical experience and SLP training/education, the student demonstrates emerging skills inconsistently. Supervisor must provide a moderate level of support via verbal reminders, prompts, cues, etc. Student demonstrates awareness of behaviors needing to be addressed or attempts to resolve clinical problems, but requires supervisor guidance and support to do so.

3. **Skill is present.** In the context of the student’s clinical experience and SLP training/education, the student demonstrates expected skills, but further development or refinement of skills is required to achieve efficiency. Supervisor must provide on-going feedback or monitoring. Student demonstrates awareness of behaviors needing to be addressed and attempts to resolve clinical problems during sessions.

4. **Skill is consistent.** In the context of the student’s clinical experience and SLP training/education, the student demonstrates skills that are well-developed and implemented consistently. Supervisor acts as a collaborator in treatment planning. Student is aware and can modify behavior in-session and self-evaluate after the session. Supervisor is needed to suggest possible alternatives. Student’s problem solving shows evidence of critical thinking.

5. **Skill is automatic.** In the context of the student’s clinical experience in various settings, and completion of SLP training/education, the student demonstrates expected skills independently and efficiently. Supervisor serves as a consultant/colleague. Student demonstrates independent case management and problem solving in multiple settings to address a caseload of diverse client needs.
6. CLINIC SAFETY POLICIES AND PROCEDURES

*All clinical staff and students should follow these guidelines—see the Exposure Control Plan and Emergency Action Plan located in room 170 for more detailed information*

6a. Equipment
Decontamination, cleaning, disinfection, and sterilization of multiple use equipment before reuse should be carried out according to specific infection control policies and procedures (as detailed in the Exposure Control Plan).

All reusable clinical materials (e.g., games, toys, etc.) and work surfaces (e.g., table tops, arm rests on chairs, mirrors) should be cleaned and disinfected after each use. Clinical materials may be cleaned with an approved disinfectant (e.g., Lysol) or household bleach solution (these are kept in each treatment room). Clinicians will sign up 2 times each semester to refill bleach bottles and restock clinic cupboards with cleaning supplies, first aid items, tissues, cups/water bottles, etc.

Reusable audiological equipment (e.g., tympanometry probe tips, headphones) must be cleaned/disinfected following the Clinic Equipment Cleaning Protocol. For each new client, disposable items such as otoscope tips should be used and then properly discarded in a waste container.

6b. Hand Washing
- Wash hands immediately if they are potentially contaminated with blood or body fluids containing visible blood.
- Wash hands before and after treating patients/clients.
- Wash hands and have clients wash hands before and after snack time in sessions.
- Wash hands after removing gloves.
- Wash hands after cleaning/disinfecting room and materials.
- Follow the basic hand washing technique:
  - vigorous mechanical action whether or not a skin cleanser is used
  - use of antiseptic or ordinary soap under running water
  - rinsing for at least 20 seconds
  - thorough hand drying with a disposable paper towel to help eliminate germs
- An alternative when hand-washing is not feasible is to use an alcohol-based disinfectant gel (i.e., hand sanitizer).

6c. Gloves
- Wear gloves when touching blood or other body fluids containing visible blood.
- Wear gloves when performing invasive procedures on all patients/clients. This includes performing an examination of the oral speech mechanism; using a laryngeal mirror, oral endoscope, or nasoendoscope; and assisting with oral-myofunctional tasks.
- Wear gloves to clean/disinfect all equipment, unless otherwise indicated.
- Change gloves after contact with each patient/client or after touching an item (e.g., your pen) that was not disinfected immediately prior to donning the gloves.
- If a glove is torn, remove the glove and use a new glove as promptly as patient/client safety permits.
- After removing gloves, wash hands immediately.
Discard gloves in the room before exiting.

6d. Spills
To clean and decontaminate spills and/or splashes of blood or other bodily fluids:
- Maintain a barrier between the spill and your own body. Wear a pair of gloves, and eye protection (safety glasses are located in HS 178 and 185.)
- Surround spill with disinfectant.
- Cover with paper towel.
- Saturate paper towel with disinfectant.
- Allow for contact time per disinfectant instructions.
- Paper towels can be thrown in regular waste.
- Clean surface with a freshly prepared 1:9 hydrochloride (e.g., household bleach solution).
- Notify clinic supervisor and/or Clinic Coordinator immediately.
- In the event of a large spill or when items cannot be completed disinfected (e.g., items that are disposable such as fabric chair seat or carpet), call Environmental Health and Safety (EHS) at (6-3277) and the Physical Plant Blood Team at (6-6225).

6e. Human Blood Borne Pathogen Exposure Incident Instructions
1) Rinse or wash affected surface immediately and apply first aid.
2) Report incident to supervisor immediately.
3) Report to student health to seek medical attention.
4) Return copy of the incident report and all relevant medical reports to the Division office
5) A copy of the report should be sent to the EHS office

6f. Cleaning Solutions
*Gloves and protective eyewear must be worn during all cleaning/disinfecting processes unless otherwise indicated*

Disinfectants
- A fresh mixture of household bleach and water (1:9 parts) is mixed each week for use in each clinic treatment area. At the end of each week, the mixture is disposed of allowing the containers holding the mixture to air dry before each new mixture is made.
  - It is not necessary to wear personal protective equipment (PPE) when using this solution.
  - This solution is changed each week by the materials room attendant.

Sporox
- The Sporox is premixed and ready to use in HS178 (Hearing Aid Lab) and HS185 (Cleaning room).
- Pour two cups of Sporox liquid into the clearly marked container.
- The Sporox should be changed every 21 days. The materials room attendant will change the solution and log the date on the sheet posted near the container.
- Dispose of used Sporox into the Hearing Aid Lab or Cleaning room sinks.
- Should you have any reaction from contact with the Sporox, refer to the warnings and precautions sheet posted inside the cabinet where the container is located and notify the appropriate Clinic Coordinator
immediately.

**Maxicide**

- The Maxicide solution must be mixed before use. The two agents (one powder one liquid) become active once mixed.
- After Maxicide mixture is made, pour the designated amount into the marked tubes in the Cleaning room.
- The Maxicide in the tubes and any unused solution should be discarded after 21 days into the sink. Log the date when the mixture is made on the container and place the same information on the base of the tubes with the Maxicide mixture.
- Should you have any reaction from contact with the Maxicide, refer to the warnings and precautions sheet posted directly on the container and notify the Clinic Coordinator immediately.

**6g. Universal Precautions**

1. Assume all human blood, bodily fluids and unfixed tissues are contaminated with Human Immunodeficiency Viruses (HIV), hepatitis viruses including Hepatitis B Viruses (HBV), Hepatitis C Virus (HCV), and other Blood Borne pathogens. Pathogens are disease-producing microbes. These human materials are thus considered biohazardous in any workplace.
2. Any direct physical contact with human biohazardous materials is to be avoided. Maintain a barrier between yourself and the potential contaminant. Use personal protective devices such as gloves and eye protection when appropriate. Gloves should be worn during all invasive procedures, including oral peripheral examinations and otoscopic examinations. Protective glasses should be worn when grinding hearing aids.
3. Know the signs and symptoms of Hepatitis B Virus, and Human Immunodeficiency Virus infections. Report unexplained significant illnesses, rashes and fevers to your supervisor if you have handled human biohazardous materials.
4. Understand the biohazardous tasks you must do in your job classification or category as detailed to you in the Blood Borne Pathogen training.
5. Become proficient at using personal protection (e.g., gloves, masks, eye shields, etc.) before becoming in contact with biohazardous materials.
6. It is highly recommended that you obtain the vaccination against Hepatitis B. Notify the Clinic Coordinator when this series has been completed.
7. Avoid needle sticks, cuts, abrasions, and splashes in work associated with human hazardous materials. Protect face and broken, irritated or abraded skin from human materials, and avoid aerosols.
8. Always use good hygiene work practices including antiseptic techniques, spill clean-up, medical waste containment and **regular, thorough hand washing** with soap and water and/or non-water hand sanitizers, especially after removing gloves or when leaving your work area.
9. Dispose of biohazardous human materials and contaminated, disposable lab ware properly. Contaminated recyclable lab equipment must be sterilized. Protect yourself, patients/clients, staff and visitors from accidental exposure.
10. Decontaminate all reusable protective gear immediately after use following specific clinic procedures.
11. Clean work areas thoroughly with disinfectant or a mixture of household bleach before leaving your work area.
12. Report all accidental exposures to Clinic Coordinators and supervisors and seek medical follow-up. The attending healthcare professional will want to know the individual’s name who was the source of the contaminate, if possible. Do NOT save specimens for HIV or HBV testing.

13. Obtain proper biosafety training and become proficient in performing all biohazardous tasks assigned to you.

* These Universal Precautions must be strictly followed by all Division supervisors, graduate clinicians, and student observers in all settings *

You will complete UW’s Bloodborne Pathogens training and will sign a training form before your first client contact. This training will be completed annually.

6h. Hepatitis B Vaccine
Most off-campus sites require a Hepatitis B vaccine before initiating a practicum at that site. Since students may not know their site’s requirements until it is too late to order the serum, it is strongly advised that all students obtain the Hepatitis B vaccine while on campus during the first three semesters.

If students choose to receive the Hepatitis B vaccine, they will receive a series of three shots across a six-month period. The Hepatitis B series takes at least 6 months to complete, so plan accordingly or run the risk of the externship being delayed. Students may receive both vaccines at the University of Wyoming Student Health Center. Students are responsible for the cost of this vaccine.

You will sign a form stating that you have either received the vaccine or decline it at that time prior to your first client contact.

6i. Health Insurance
Graduate students enrolled in at least 4.5 credit hours of campus instruction are charged automatically each semester unless a waiver is signed. The deadline for signing the waiver will vary for each semester. Students who are on externship (enrolled in section 80) are not automatically enrolled for health insurance (this includes campus track students enrolled in 5270 and 5290 externships and Orals in their final semester). To obtain health insurance, you must a) petition for the optional student fee package through the graduate school, and then b) complete an enrollment form in the Student Health Insurance office. Contact the Student Health Insurance offices at 307/766-3025 for further information.

6j. Liability Insurance
The University of Wyoming provides general and professional liability coverage for clinical undergraduate observation students and graduate students in the Division of Communication Disorders for a nominal fee. Such coverage shall not apply to activities on the part of students which are not part of or are beyond the scope of the educational program.

Recently, an increasing number of externship sites have been requesting higher liability coverage than what is offered through UW. If the student wishes to complete an externship in one of these sites, this additional professional liability insurance coverage is the responsibility of the student. Verification of this additional liability insurance must be provided to the Clinic Coordinator by submitting a photocopy of the page(s) from the insurance policy, which indicates who the coverage is with and effective dates of the policy. Students who fail to provide written verification of this additional coverage will not be allowed to start their externship at the site requesting additional coverage until verification is complete. A relatively easy and inexpensive way to
obtain additional personal liability insurance is through the National Student Speech Language and Hearing Association (NSSLHA). Contact them at their web site: www.nsslha.org.

6k. Emergency Response Procedure
Client welfare and safety are paramount while clients are attending the UW Speech and Hearing Clinic. The following steps are procedures that should be followed to ensure the client safety is maintained.

If an emergency arises that is client-centered:
- Stay with the client
- Call/yell for assistance (e.g., open door and yell for help)
- Use phone in treatment room and call 9-1-1
- Offer client assistance (e.g., first aid, CPR, etc.)
- Stay with client until medical assistance arrives
- After situation is resolved, report incident to clinical supervisor/director
- Supervisor/director will follow-up with Risk Management and others as needed

If an emergency arises that is environmental (fire, tornado, etc.)
- Remove or assist client away from the building
- Move client to a safe location away from windows/debris if a tornado
- Remain with the client
- Call 9-1-1 to report situation (use a cell phone)
- After the situation has resolved, report incident to clinical supervisor
- Return to building only after an “all clear” has been given by the authorities.

*See Emergency Action Plan in room 170 for more detailed procedures*
7. EXTERNAL CLINICAL PLACEMENTS
SPPA 5270/5290
The externships are viewed as an extension of academic and clinical experiences. Clinical instruction continues in these experiences. A student’s academic and clinical performance may be shared with external supervisors to enable them to best support the student’s learning.

Graduate students complete two full-time, twelve-week externships following completion of coursework and SPPA 5030 requirements. Students register for one externship in the Spring and one in the Summer semester, but the beginning and ending dates do not align with semesters. One externship is to occur in an educational setting (a school or early childhood program), and one is to occur in a medical or clinical setting. Most students will complete the educational internship first. The order of externships are arranged and determined by the student and Externship Coordinator.

Determination of a student’s preparedness for externships is subject to approval by the clinical supervisors and the faculty. This may include meeting a required number of clinic hours and/or demonstrating the knowledge and skills appropriate for the externship (e.g. successfully completion of coursework). Thesis students must complete the prospectus meeting before entering into externships.

Students will be expected to perform in a professional manner and demonstrate growth toward a life of professional service. These externships are more like work settings, although clinical guidance and supervision continues. From their practica and externships, the student needs to gain experiences covering the breadth of the lifespan across the Big 9 disorder categories. If a student is dismissed from an externship, they automatically receive a U and must enroll to repeat the externship in a future semester.

Students are expected to be able to relocate in order to complete these externships. Travel and living arrangements for the externships are the student's responsibility. A letter to financial aid for loan repayment purposes can be issued by the Division indicating the practica are full-time experiences despite their part-time credit hour status (i.e., 6 SCH).

Community Placement and Externship Supervisors may be unfamiliar with CALIPSO. If this is the case:
- Supervisors will be added in CALIPSO as needed. Students should guide their supervisors through the CALIPSO one-time registration process and assist in answering any questions that may arise.
- A copy of all supervisors’ ASHA certification cards and, if applicable, state licenses must be given to the Clinic Coordinator before the end of each clinical rotation. CALIPSO allows for these documents to be uploaded too.
- Students should include notes to supervisors in the “Comment” box regarding client initials, time supervised, etc. to ensure adequate supervision amounts are met.

7a. Process of Securing an Externship
General Information on Externships
The program will provide opportunities for two externships. In order to complete the program on time, students will need to work with our existent framework and processes described below. Our program does not allow students to “make their own” externship opportunity, as you will see below externships are complicated agreements that involve many parties and aspects beyond student-supervisor. Students are an integral part of the externship process but never to arrange their own externships.

Medical externships include hospitals, medical sites, skilled nursing facilities, outpatient therapy, and clinics (this can include in the home Part C services). For our program, medical externships are available only at
established sites listed in the Externship Listings, OR in rare circumstances the Externship Coordinator will inquire with an additional site if the site is in the “Mountain-West region.” A cooperative education agreement (i.e., contract) must be approved by the University and externship facility, and hospital /medical/clinic sites have restrictions and several layers of approval. Typically, it takes 8-12 months to execute a contract in one of these sites, and general counsel and legal consultation expenses make this a costly process. These sites in particular have been increasingly difficult to secure, and we have been turned away from sites outside the region because they simply prefer to train students who are from local programs or who are residents in the area.

Bottom line: **Students should plan on completing their medical externship at one of our existent sites from the Externship Listings.**

**Educational externships** include schools, preschools, and early intervention programs. Our program has more than enough cooperative education agreements with educational externship sites to meet the needs of our students. We strongly encourage students to select from our existent sites, however- we will make up to 2 inquiries if a student would like to request an educational internship in a given educational site for which we do not currently hold a agreement. Consult with the Externship Coordinator prior to completing your Externship Request.

**Process/Steps**

Students will follow the externship application processes as established by the Externship Coordinator.

**SharePoint** will be used to organize this process.

Within SharePoint you will find:

- Externship Listings
- Externship Request (an electronic form)

Students should bear in mind that each externship request and each student’s circumstances are unique and the timing for all aspects will vary depending on the site. Many of the educational sites will not be able to commit or respond to requests until the academic year has begun. Some of the medical sites may interview or screen in March while other may do this in September or not at all.

**7b. Externship Guidelines**

The Externship Coordinator will work from the student’s externship requests, students may not make changes to these requests or begin to pursue other opportunities. The Coordinator will make inquiries, and in some instances will be required to select 1 or 2 students who are given greenlight to inquire or apply for an externship.

As the internship matching process occurs, students may learn 1) a site is not accepting students 2) students were already selected 3) he/she was not matched or selected to apply to a site 4) or other issues arise or the site is not a viable option. Students will need to consider alternate options in order to graduate on time, including options that he/she may not have included in his/her externship request.

The implementation of the Higher Education Act and current state authorization regulations has affected clinical practicum choices. At this time, the Division of Communication Disorders will not be placing students in clinical practica in certain states. We have adopted this policy to comply with regulations in these states. See the Division website for the list of eligible states ([http://www.uwyo.edu/comdis/graduate-study/state%20reauthorization-licensure.html](http://www.uwyo.edu/comdis/graduate-study/state%20reauthorization-licensure.html)).
The Externship Coordinator decides on the steps for all externship requests. Students must have approval or “greenlight” prior to making any contact with any externship site/possible supervisor. We have been “shut out” of sites in the past because multiple students made requests without approval. In some instances sites have rules about who is contacted and what information is shared, the Externship Coordinator will navigate this process not the student.

Upon approval, graduate students may make initial inquiries with sites that they are considering for an externship. This means that they can obtain the name, telephone, or e-mail address of a contact person or a possible supervisor at the facility so that the Externship Coordinator can make contact. After the initial contact, the Externship Coordinator will provide the student with further instructions regarding the externship application process. Some sites may require electronic application in order to be considered for an externship and some applications require a fee.

There have been instances where the University does not approve a site because of the site’s contracting wording or legal requirements. Students will need to work with the Externship Coordinator at considering alternatives if this should occur.

There also are occasions where a site that was secured unexpectedly “falls through.” Students will need to work with the Externship Coordinator at considering alternatives if this should occur.

Some sites handle multiple requests from students, and may have an interviewing process or a process by which students apply over email with a cover letter and resume. Students will be informed if they have the greenlight to apply to these sites, and they will be provided with general timelines and possibly with deadlines. Some sites will limit the number of students who can apply from a given program, the Externship Coordinator will select who has the greenlight.

Students should refrain from writing the Externship Coordinator to request updates on externship status. As information is available, the Externship Coordinator will update the student.

Many sites will require completing documentation before the externship begins, including another criminal background check, drug screening and finger-printing, or purchase of facility attire, such as scrubs or lab coat. Students are responsible for the cost of these extra requirements and documentations.

7c. Supervisor Requirements
Like the University supervisors, the externship supervisor(s) must hold the following minimum credentials:
   a) A Master’s degree in Speech-Language Pathology
   b) Certificate of Clinical Competence in Speech-Language Pathology
   c) State license and/or Department of Education Endorsement (if applicable)

A copy of the supervisor’s current ASHA certification card and state license, if applicable, must be given to the Externship Coordinator within the first 6 weeks of the externship. This applies to all supervisors that participate in clinical education during the externship. The supervisor must supervise a minimum of 25% of each client’s treatment and/or evaluations (including screenings). It is the student’s responsibility to notify the Externship Coordinator if the externship supervisor is not maintaining the proper levels of supervision. Clock hours that are not properly supervised will not be counted in your accumulation of ASHA hours. Weekly clock hours of client contact are recorded on CALIPSO.

Mid-term conference calls will be held during each externships. This conference will parallel the documentation of the student’s overall mid-term performance using the CALIPSO Performance Evaluation form. At mid-term
the student must be informed of current grade (S/U) and an understanding of what is needed to improve performance. A final evaluation (CALIPSO) of the student's overall performance is required from the supervisor and should be returned to the Externship Coordinator by the end of the externship. Note that expectations after the midterm continue to increase, and students who do not perform to expectation or who are struggling should inform the Externship Coordinator as soon as possible so that conference calls and remediation can be discussed. Students who fail an externship do not receive any clock hours for that site, and must apply and enroll for a repeat of the externship in a subsequent semester. Additional remediation steps will be required.

7d. Student – Externship Supervisor Communication

Each student should be familiar with the externship site's policy regarding lines of communication and professional responsibilities. Site supervisors bear the ethical and professional responsibility for management of clients seen by the student. This means that the site supervisor must approve all recommendations, referrals, and discussions regarding client management before they are implemented. The Externship Coordinator is responsible for communicating proper supervision practices to the supervisor prior to the start of the externship and if needed, re-assigning a graduate student to another site or supervisor if supervision is not adequate. Respect for professional lines of communication is essential to good client management and avoids placing the student and clients in the position of having to respond to competing and contradictory messages. To gain maximum benefit from this clinical training, students need to maintain open lines of communication with their supervisors. Many unnecessary days of anxiety and difficult situations can be avoided if the supervisor (and Externship Coordinator) are kept informed.

Treat this experience as it is your first professional job. For example, if you are going to be absent, your supervisor must be notified. Any missed days are expected to be made up. However, the student is not expected to “fill-in” for an absent certified clinician nor manage a caseload that is not commensurate with his or her clinical competency. Regardless of what has been learned previously, approach externships as opportunities to develop emerging competencies and acquire new ones.

7e. Student Expectations for Externships…Being a Student and a Professional

Although each externship site is unique and may have specific guidelines for students to follow, some general guidelines are meant to serve as recommendations for professional behavior in any site. Students should consult their immediate site supervisor to discuss expectations during the externship. Doing this early can avoid many unnecessary miscommunications for the student and the supervisor. If issues are not resolved, the student should notify the Externship Coordinator so interventions can be made.

- Only the clinical supervisor has been granted clinical privileges at their site. The site supervisor must approve all clinical services you provide.
- These extensions of your academic and clinical education are to provide you with opportunities to learn and not solely to fulfill the required clock hours for graduation. Be an equal partner in the responsibility of your learning.
- Treat the externship as you would a job. Demonstrate a positive work ethic. Adhere to the work hours followed by your supervisor.
- Attend the externship for the scheduled duration. Do not arrange time off for vacations or study.
- Be prepared and ready to work with clients.
- Show up on time and where and when you are expected to be someplace. Be accountable to your supervisor when you are on the job.
• Notify your supervisor and office staff immediately of any absence. Offer to make up any missed days if the supervisor’s schedule allows.

• During any “downtime” from client care, engage in learning opportunities such as treatment planning, studying evaluations, reviewing suggested readings, practicing writing notes or evaluations and helping with miscellaneous facility needs.

• Be involved and absorbed in the site you are participating in. Do not turn down an opportunity to gain more experience because you have already obtained the required clock hours for a particular disorder category.

• Participate and share in your learning by offering to conduct an in-service or share your recent academic background with your supervisor or other related staff. Reciprocal teaching is one of the small ‘perks’ our program can offer to supervisors for their service.

• Maintain a professional demeanor. Dress and act professionally. Be aware of what you say in front of clients, family members and other staff members and how it may be perceived.

• Remember that you are representing yourself, the University of Wyoming, the Division of Communication Disorders, and the particular site and supervisor with whom you are working when you are working with clients. What impression will you leave each of them?

7f. Supervisor Expectations for Externships

Although each externship site is unique and may have specific guidelines for students to follow, these general principals are meant to serve as recommendations for site supervisors about the overall clinical learning process. Students’ learning will be commensurate with the opportunities provided by each particular site. The Division recommends that supervisors consult with their students early in the externship to discuss their expectations. This may avoid many unnecessary miscommunications between the student and the supervisor. If issues are not resolved, it is important that the supervisor notify the Externship Coordinator immediately so adjustments can be made.

• Only the clinical supervisor has been granted clinical privileges at their site. The site supervisor is expected to approve all clinical services provided by the graduate student.

• This extension of academic and clinical education is to provide students with opportunities to learn, gain hands-on exposure, and to fulfill the required clock hours for graduation and ASHA certification. Supervisors should assist the student by providing a well-balanced clinical experience (treatment, screenings and evaluations).

• Repeated opportunities to learn are a hallmark of any externship. Supervisors should feel confident in providing students with ample opportunities to improve knowledge and skills regardless if the student has obtained “required clock hours” for a particular disorder category.

• The externship should be treated like a job. Supervisors should not require students to perform duties in their absence to “make-up” for lost productivity nor should supervisors expect students to compensate for staffing shortages by being “free labor”. Supervisors should notify their students if they are to be absent. Coverage by another certified SLP within the facility is acceptable. If the supervisor’s schedule allows, students should offer to make-up any missed days. Supervisors should contact the Externship Coordinator if attendance is a concern.

• During any “downtime” from client care, supervisors should assign students learning opportunities such as treatment planning, studying evaluations, reviewing suggested readings, practicing report and note writing and learning about the practical aspects of billing and administration of their particular facility.
Supervisors may request that students extend their learning by having them conduct an in-service or share their academic or clinical knowledge with supervisors or other related staff.

Supervisors should submit all documentation required by the Division in a timely manner. This includes a copy of ASHA Certification cards, state license, if applicable, bi-weekly feedback forms, and mid-term and final performance evaluations on CALIPSO.