Fall 2012

BOSSIER PARISH COMMUNITY COLLEGE

PTA Program Clinical Newsletter

CAPTE On-Site Visit Scheduled for Fall 2012

Ten years have passed so rapidly, but it is once again time for the BPCC PTA program to host a team from CAPTE for an on-site accreditation visit. BPCC was first accredited by the Commission on Accreditation of Physical Therapy Education (CAPTE) in May of 1998 and again in May 2003. This third accrediting team visit is scheduled for November 11-14, 2012.

The team will be composed of three members, a PT that is the program director of a PTA program, a practicing full-time PTA that is a graduate of a CAPTE accredited program and an administrator of a 2-year institution that houses a PTA program.

CAPTE sets the standards for entry-level PTA programs designed to reflect contemporary practice. These standards encourage consistency among education programs while promoting a culture of ongoing assessment, innovation and improvement. While on campus, the team will visit with faculty, administration and all areas of student services (library, financial aid, etc..). Also on the team's agenda will be gathering feedback from parties of interest including: clinical instructors, graduates, currently enrolled students, and employers. Those with knowledge of BPCC PTA student/graduate performance are encouraged to be available and share information at the different meetings that will be scheduled on campus during this time. Meeting times will be communicated via email/phone calls and open invitations on the Program website and facebook page.

The information gathered by the team, in combination with the BPCC PTA Self-Study report submitted in early September, will be used to make recommendations to the Commission regarding the accreditation status of the program. The team will present their recommendations and closing remarks about the program at an EXIT summary meeting scheduled for noon on the final day of the visit (Nov 14, 2012—location TBD).

All interested parties are invited to participate in the meetings during the visit and to attend the closing remarks presentation!

Top 5 Qualities of a "Great" Clinical Instructor:

Based on years of student feedback, this "top 5" list includes those behaviors and skills that students perceive as defining a "great" clinical instructor. All CI's, whether experienced or new to student supervision, can benefit from self-assessing their strengths/weaknesses in these 5 areas:

#5— "***Made the expectations very clear***". It can be very confusing for a student to jump from one rotation/setting to another. Expectations regarding the student's role in patient care can vary widely. A CI who (a) is familiar with Program expectations for the experience and (b) verbalizes on day 1 to the student what they anticipate in terms of level of independence and progression toward independent function is laying the groundwork for a "great" clinical rotation.

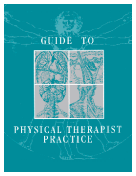
#4— "***Modeled ethical/professional behavior***". Students are expected and required to demonstrate affective skills consistent with being a "professional" and they really notice and appreciate it when clinical instructors actively work to role-model those professional behaviors. CI's who, for example, point out the ethical importance of accurate billing and documentation, who manage to avoid inappropriate conversations about patients/staff/former students , who show strong work ethic, and who are passionate about their profession and the quality of their patient care get high marks from students.

#3—"***Gave me a lot of feedback***". Students thrive on and grow from feedback that is (a) regular/frequent (b) is constructive and non-judgmental and (c) is delivered in private. One good technique to incorporate (using these above guidelines) is to share with the student following each patient interaction or treatment session what was good and what you might have done *differently* that may have been more effective or efficient.

#2— "***Challenged me to think critically***". The ultimate goal of clinical education is to teach a student how to "pull together" information and see the "big picture". CI's who ask students to look at a POC and come up with interventions, brainstorm when and how to progress a patient, or give rationales for decisions related to patient care are helping students achieve this goal. Additionally, students really like CI's who "think out loud" as they review exam findings, write goals, or modify a POC, modeling this critical thinking process.

#1—"***Was non-threatening***". The process of learning will always include making mistakes and answering questions incorrectly. A "great" clinical instructor understands that a student's natural tendency is to "feel dumb" and he/she works to take the pressure off—to encourage learning from mistakes without anxiety or fear of embarrassment.

Disablement Model as a Framework for Clinical Instruction

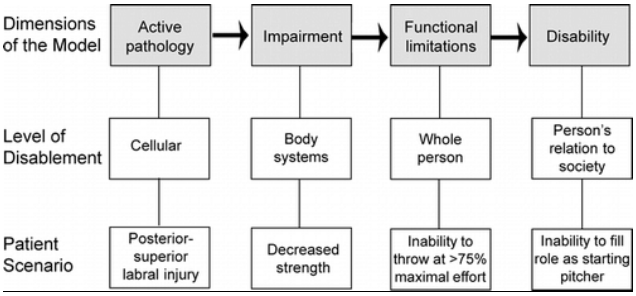


APTA's *Guide to Physical Therapist Practice* describes the **Disablement Model** as a framework for our profession. This model focuses not solely on a patient's disease/pathology, but on the consequences of that pathology at the level of the person and at the level of society. And while experienced PTs/PTAs inherently understand and are able to apply that model to daily practice, students often struggle with seeing the patient from this "big picture" perspective.

Clinical instructors can facilitate student critical thinking by prompting students to view patients considering all 4 levels of the Disablement Model:

Level 1—The pathology/disease/lesion. Not all "hip ORIFs" or "Parkinson's disease" patients are the same, but it is important for students (you should expect/ask them) to:

- understand/explain (*or have them do homework to research*) the physiology of the patient's medical diagnosis and how that diagnosis is made. Examples: What anatomic structures are involved with shoulder "impingement syndrome"? What's happening (going wrong) in someone with "COPD"? What tests/assessments are used to diagnose/confirm an Achilles' rupture?
- identify the anticipated impairments associated with that pathology and connect that to the PT exam findings. Examples: Connecting sensory deficit exam findings to diagnosis of diabetes. Connecting shoulder ROM impairments to diagnosis of adhesive capsulitis.
- recall any interventions particularly indicated or contraindicated for the pathology and connecting that to the PT POC. Examples: Trunk extension exercises in POC for patient with diagnosis of posterior HNP. Avoiding open chain TKE for patient with diagnosis of ACL repair.
- compare/contrast patients with the ***same pathology***/diagnosis but different impairments, functional limitations, levels of disability, rates of progress, or outcomes. Example: 2 patients with "ankle ORIF" as a diagnosis, but with different levels of functional limitation with transfers and gait.



Level 2—The impairments. Deficits identified in *individual tissues or systems* (joint ROM, strength, sensation, balance, CV function, edema, pain) are commonly the focus of a PT exam. Students should be able to:

- identify what assessments were/could be used to verify specific impairments. Examples: Volumetric measurement used to assess edema. Timed single-leg stance used to identify balance deficit. Borg scale or HR used to document limited CV endurance.
- select interventions for addressing specific impairments/goals. Example: Identifying exercises appropriate for increasing shoulder flexion ROM. Selecting modality and parameters appropriate for decreasing pain and edema.
- compare/contrast patients with ***similar impairments*** but with different underlying pathology, functional limitation, disability, rate of progress, or outcomes. Example: 2 patients with low back pain, but with different underlying pathology. 2 patients with hemiplegia, but with different levels of disability.

Level 3—Functional Limitations. A restricted ability to perform *an activity or task*. A student taking this level into consideration should be thinking about why quad weakness would "matter" to an 85 y/o SNF resident vs 40 y/o construction worker vs 5 y/o pre-school child. Students should be able to:

- hypothesize the functional activities/tasks that a patient would have difficulty with based on their impairments and ADLs. Examples: Patient has decreased dynamic standing balance—what tasks would this restrict? Patient has pain in full knee flexion—what ADL's would this limit?
- compare/contrast interventions appropriate for addressing a similar impairment in patients with different functional limitations. Example: Addressing weakness of hip extensors in patient with difficulty in sit to stand vs addressing same impairment in patient having difficulty with running/jumping .
- discuss whether to improve function it is appropriate to modify the activity/environment or address the underlying impairment. Example: A patient with restricted ability to reach overhead...is it appropriate to work on gains in strength/ROM for the task or to modify ADLs/environment to limit the need for that motion/task?

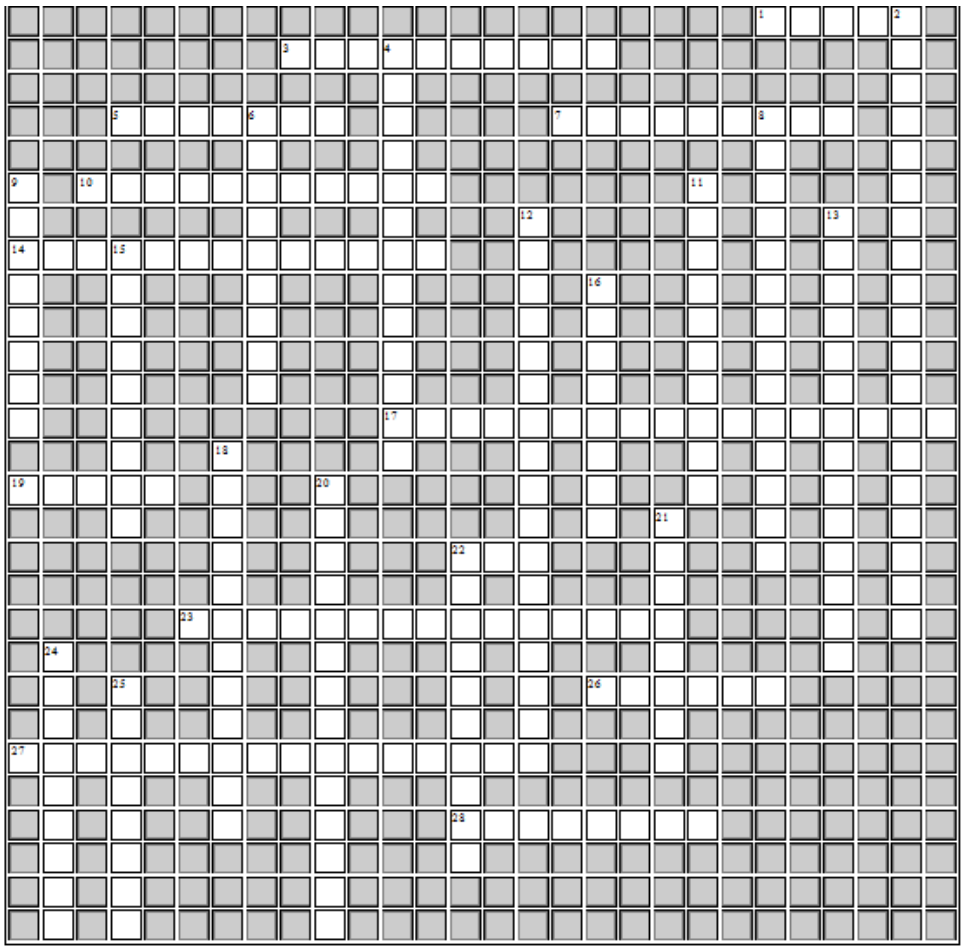
Level 4—Disabilities. Limitations in performance of socially defined "*roles*". Consider two patients, both transfemoral amputees, who present with similar impairments and functional limitations. Both wish to return to their previous "roles" of "household income provider" and "outdoor sportsman". But the two patients have disparate levels of access to social and economic support, have occupations with very different physical requirements, and while one enjoyed fishing recreationally, the other needed to climb into a deer stand for his sport. The level of "disability" for the two patients in returning to those roles may be very different. When considering this level, students should be prompted to:

- discuss the effect that the patient's pathology, impairments and functional limitations may have on ability to fulfill societal "roles" (work, recreation, social, family). Example: What effect would a patient's LE weakness and decreased ability to bend/squat have on her "role" as a nurse? On her "role" as the mother of 2 small children?
- identify environmental/activity modifications or resources (social/financial) accessible to the patient that may reduce the level of disability for that role. Example: For the paraplegic patient who wishes to return to the "role" of college student… interventions such as assisting in identifying options for public transportation (resources) and putting him in touch with other student wheelchair users (social support) may have a much greater effect on his perceived level of "disability" than merely focusing on traditional PT interventions.

Try having your students analyze each patient based on this model and watch their ability to see the "big picture" improve!

Fall Crossword Puzzle

Hey Clinical Instructors!! Try this crossword just for fun but also to get an idea of what didactic content BPCC PTA students are covering during the fall semester of the PTA Program. Challenge your PT & PTA co-workers to brush the brain cobwebs off of some of this information to help you finish the puzzle! Then feel free to quiz your fall PTA students about these subjects too!!



Across

1. peripheral nerve innervating the hypothenar muscles
3. Of conversion, conduction, or convection, the type of heat transfer occurring with use of hydrocollator packs
5. when performing passive stretching, the PT/PTA should provide enough overpressure to take the targeted tissue into this "range" on the stress/strain curve
7. the wrist and MCP's are examples of this type of synovial joint
10. during measurement of ankle dorsiflexion ROM, the stationary arm aligns with the:
14. extension of the resting knee during the Thomas test commonly indicates tightness of this muscle
17. bony landmark at risk of pressure ulcer development in patient with impaired mobility or sensation who sits for a prolonged period of time
19. common term for an indwelling urinary catheter
22. A standard unit of measure when recording the "frequency" of an e-stim modality (abbreviation)
23. Tibialis Posterior, Flexor Digitorum Longus, and Flexor Hallucis Longus ("Tom, Dick, and Harry") can be palpated behind this bony landmark
26. theory that states that bone tissue will adapt to the loads it is placed under
27. the muscle primarily responsible for scapular abduction (protraction)
28. phrase describing the waveform shape of high-volt pulsed monophasic current

Down

2. because this disease and the chronic steroid use associated with this disease causes joint instability, it is typically considered a contraindication to the use of mechanical traction
4. pulse palpated just lateral to the extensor hallucis longus tendon
6. one of the 2 ligaments making up the coracoclavicular ligament group
8. condition associated with the development of Heberden's nodes at the DIP and PIP joints
9. primary shoulder impingement syndrome is frequently a result of a structural defect of the _____
11. the range of 13-18 g/dl is normal for this blood chemistry value; levels below 8 g/dl may contraindicate PT intervention
12. a muscle that in closed chain contracts eccentrically to slow/decelerate ankle pronation/eversion
13. muscle innervated by the C7 spinal nerve
15. term for increased respiratory rate
16. term describing wound drainage that contains white bloods cells and bacteria, has an odor, and is indicative of infection
18. the amount of blood ejected from the left ventricle with each beat
20. The "unhappy" or "unholy" triad refers to a knee injury damaging the ACL, PCL and this structure
21. asking a patient to "blow" or "count" during a resistance exercise is an effort to avoid this, which can cause a dangerous rise in BP
22. the parameter associated with conventional TENS that makes it a poor choice for eliciting a muscle contraction
24. position for MMT of the gluteus medius
25. a patient with active tuberculosis should be treated using standard precautions and _____ precautions (type of transmission-based set of precautions)

It's About You!

BOSSIER PARISH COMMUNITY COLLEGE

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PTA PROGRAM UPDATE—FALL 2012

Program Admissions: 2012-2013 Class Statistics

Number of *Qualified* Applicants: 97

Number Selected: 20

Application selection formula was based on:

50% - Academic Score

- Science prerequisites weighted more heavily than non-sciences

50% - Nonacademic Score

- Observation rating form scores (completed by PT/PTAs)
- Employer rating form scores
- Interview score (written and oral components)

Timeline/procedure for *2013-2014* selection process:

- Application packet (available at bpcc.edu/pta) and rating forms due by April 15, 2013
- Pre-PTA coursework must be completed by end of spring 2013 semester

Way to Go!!

The BPCC PTA Program is very fortunate to have a large community of skilled and dedicated clinical instructors who not only model excellent technical skills but who also devote time to and energy to *teaching*. PTA students are asked to give feedback to the question "**What did your CI do well to facilitate learning?**" at the end of each rotation — See just *some* of the great things our CI's are out there doing!!

"He was constantly looking for learning opportunities for me. He used free time in between patients to point out what I did well and what he might have done differently to make the treatment more effective or efficient. He also had me write as many notes as possible, which took me out of my comfort zone, but in hindsight was *extremely* beneficial for me."

Re: Ron Payne, PTA
Melanie Massey Physical Therapy

"My CI had me brainstorm to come up with my own interventions for each patient and encouraged me to be creative. I really felt like this rotation made me a better PTA."

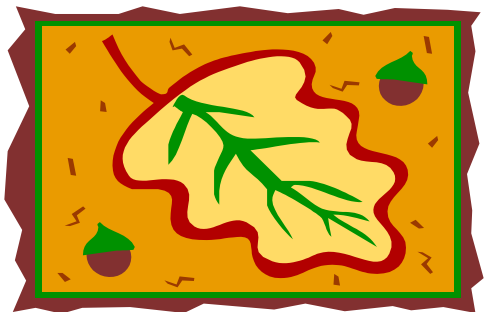
Re: Laurinda Foreman, PT
Willis-Knighton Health System

"She had me sit in on the evaluations and identify what exam findings were abnormal and how that related to the goals set for the patient and the POC. She was also really good at asking me to think out loud when she asked me questions or gave me a problem so that she could pick out what I was or wasn't understanding."

Re: Lauren Branch, PT
Willis-Knighton Health System

"My CI had me do chart reviews first and then problem solve about what interventions would or would not be appropriate that day. She also gave me independence with aspects of treatment I was comfortable with and talked me through techniques that I was less familiar with."

Re: Beth Austin, PT
Minden Medical Center



"Jonnene had amazing clinical skills. She would occasionally be the "patient" and allow me to practice manual techniques on her which was extremely helpful. I also really appreciated her integrity and character with emphasis on quality patient care and ethical/accurate documentation and billing."

Re: Jonnene Moore, PT
Willis-Knighton Health System

"She was very attentive during the rotation and regularly gave me constructive feedback (throughout the day/week) which I really appreciated. She gave me a lot of opportunities to practice note writing. She was approachable and you could really tell she enjoyed teaching!"

Re: Christin Compton, PTA
Guest Care Rehab

"Trent had me review the patient's eval and come up with interventions that would be appropriate. He really prompted me to think "out of the box" and use exercises that would specifically address each patient's deficits and goals. He was open to my ideas and suggestions—the learning environment was very interactive!"

Re: Trent Wierick, PT
LSUHSC