Clinical Learning Record

Name: ________________________________

ID#:___________________________________

MScPT Class of _______________________

The Clinical Learning Record

Each student is required to monitor and guide their own clinical placement experiences to ensure that they obtain exposure to a broad spectrum of clients: clients across the lifespan, clients with a wide variety of conditions, clients across the continuum of care. This **Clinical Learning Record** is a document designed to capture the details of your individual clinical placement experiences. It consists of three sections: a **Clinical Log,** individual placement **Learning Plans** and the **Interprofessional Competency Self-Assessment.**

The **Clinical Log** includes three checklists: client conditions/diagnoses, assessment procedures and treatment interventions. As you encounter clients, keep track of their conditions and/or diagnoses. When you work with a client yourself or watch another physical therapist provide care, track the types of assessments and interventions you observe or perform. The Clinical Log is relatively comprehensive but you may also find it necessary to make additions. At the same time, the checklists offer an overview of what you may have the opportunity to see/experience but you are not expected to see/complete everything on the lists.

The **Learning Plans** section includes forms for recording of your individual placement learning goals and plans, a listing of unique placement opportunities (e.g. observing a surgery) and a brief summary of your areas of strength and those needing further development. For each placement you are required to develop a learning plan that is specific to the area of practice and one which incorporates your level of knowledge, skills and abilities. Typically you will draft a learning plan in the first few days of the placement. Your supervising physical therapist /clinical instructor (CI) will assist you in finalizing the Learning Plan. During the placement, the Learning Plan will help to guide both you and your CI and will provide you with an objective marker of your growth.

You will build your Clinical Learning Record as you progress through the MScPT program. It is an evolving document in which you will keep a written record of your experiences as they accumulate. Within each placement, you and your CI(s) can review the Clinical Log and past Learning Plans to build on previous experience and ensure a diversity of exposures. It should be one continuous document that you present in hard copy at each placement.

You are responsible for keeping your Clinical Learning Record up to date. You will be required to submit it to the Academic Coordinator of Clinical Education following each clinical placement. It will be evaluated for completeness and appropriateness of the Learning Plan. Credit for a clinical placement may be withheld if the Clinical Learning Record is not submitted.

Upon graduation from the MScPT program this clinical record may serve as an addendum to your curriculum vitae, providing an overview of your clinical experience as a PT student.

Learning Plan Expectations

Learning Plans allow you to be actively involved in your learning. The Learning Plan for each placement should be developed in collaboration with the CI. It is the responsibility

of the student to initiate the discussion about goals, to present a draft learning plan to the CI and to be open to suggestions that may be put forward by the CI. Learning plans should:

- Increase your abilities as a self-directed learner
- Provide increased direction to the placement
- Focus and provide structure to the feedback you receive
- Outline two or three specific goals for each placement
- Take into account your goals, as well as the facility's and the university's goals (within the course outline for the placement)

Learning Plans should not limit the experiences or opportunities within a placement.

The SMART (Meyer, 1999) formula for writing goals should be utilized. Goals should be:

- Specific – focused and detailed
- Measurable – desired level of success and how it will be evaluated is clear
- Action Orientated – plan is broken down into workable steps
- Realistic – meaningful and relevant to area of practice
- Timeline – achievable within the placement

Examples of Appropriate Learning Plan Goals

Example 1:

Placement # 1 (PTHER 517) – Introductory
Goal # 1: By the fourth or fifth day of placement, I will have independently completed a client interview and obtained a thorough client history.
Action Plan/Resources: I will observe at least 2 interviews being completed by my CI prior to doing one on my own. I will review 3 patient charts/PT notes and the site documentation guidelines.
Outcome Measure: My CI will observe the interview and/or review my documentation and will find it comprehensive.
Final: On the final morning of placement I interviewed Mr. K., a client with COPD. I was able to complete the interview independently as per my goal. CI Feedback: My strengths included my empathetic manner, comprehensiveness of both the interview and my draft documentation. Areas for improvement include streamlining of questions and incorporating active listening into the interview.

Example 2:

Placement # 4 (PTHER 522) – Private Practice MSK
Goal # 1: By the end of this placement I will be able to independently carry a varied MSK caseload of at least 8 – 10 clients for whom I am providing comprehensive assessment, treatment and education.
Action Plan/Resources: Within the first 2 weeks, I will observe my CI perform assessments and interventions on clients within her caseload. I will assess 2 – 3 new clients each week and build my caseload. I will review protocols and guidelines to increase my knowledge about conditions typically seen on this service.
Outcome Measure: After reviewing my notes and discussing my patients with me, my CI will find my assessments, treatment plans and patient education to be comprehensive and appropriate.

Midterm review: After week 2 I am carrying a caseload of 5 patients – 1 Shd, 2 C-Spine, 2 Knee and 1 Achilles repair. I have needed some assistance from my CI to ensure completeness of the C-Spine assessments and for progression of exercises with all patients. Basically I am on track but still need to continue to become more efficient in my time management of the caseload.
Final: My caseload in the last week has included 14 patients with a variety of conditions so I have surpassed my goal in terms of number. CI Feedback: My strengths include being able to complete a comprehensive scan and peripheral joint assessment in 30 minutes, choosing appropriate interventions and using clear language when providing instructions or education to patients. Areas for improvement including progression of therapeutic exercise, conciseness of charting, and spinal assessments (especially lumbar spine).

Examples of Inappropriate or Incomplete Learning Goals

- To see a total joint replacement surgery in the first week of placement.
- To reach the 40% requirement for cardiorespiratory caseload.
- To shadow the Occupational Therapist.
- To gain knowledge in chronic pain.
- To become an evidence-based clinician.

Overall the inappropriate learning goals above are too general. Although some of these may be possible to achieve or encounter within a placement, the focus of goals should be on improving your own clinical practice knowledge, skills or professional behaviors.

The Learning Plans section also includes a subsection for listing placement experiences like observing a surgery, attending a specialized clinic, etc. General areas of strength and those needing further development can also be listed for consideration where possible when crafting subsequent placement learning plans.

The **Interprofessional Competency Self-Assessment** document will enable you to track your progression through the program as you are exposed to new interprofessional teams and master some of the competencies. This is to be completed at the end of each placement and handed in for review.

Clinical Placements

Record information regarding dates, site, location, area of practice, supervising physical therapist(s) for each placement.

Placement #1 - PTHER 517	
Facility:	Dates:
Area of Practice:	Clinical Instructor:

Placement #2 - PTHER 518	
Facility:	Dates:
Area of Practice:	Clinical Instructor:

Placement #3 - PTHER 520	
Facility:	Dates:
Area of Practice:	Clinical Instructor:

Placement #4 - PTHER 521	
Facility:	Dates:
Area of Practice:	Clinical Instructor:

Placement #5 - PTHER 522	
Facility:	Dates:
Area of Practice:	Clinical Instructor:

Placement #6 - PTHER 523	
Facility:	Dates:
Area of Practice:	Clinical Instructor:

A. Conditions / Diagnoses Checklist

Instructions: Keep track of the types of conditions, diagnoses and/or problematic body regions you encounter with clients. Mark in the first column with a √ when you have seen or provided care to a client with the condition. Provide some details in the next column. Some conditions may fit under more than one heading and additional conditions can be added at the end of the list.

Example:

Conditions / Diagnosis / Body Region	Seen in Placement	Comments/Details
Cardiac – CHF, MI	√ √	CABG, Mitral valve repl
Shoulder (e.g. disloc GH, Rot Cuff lesion, instability)	√ √ √	Total Shd, # Humerus, Rot Cuff
Osteoporosis	√	Osteoporosis Ex class

Conditions / Diagnosis / Body Region	Seen in Placement	Comments/Details
Pneumonia		
Asthma		
CF		
COPD		
Cardiac – CHF, MI		
ARDS / Multi-organ failure		
RSV / Viral Infections		
Post-Surgical (e.g. Abdominal, ENT, Thoracic, Vascular)		
Contusions/ Sprains (e.g. quads, hamstrings)		
Fractures (e.g. Femur, Tibia, Colles)		
Overuse/ Repetitive strain (e.g. Achilles tendonitis)		
TMJ (e.g. hypomobility, locking)		
C-Spine (e.g. strain, disc lesion, whiplash, torticollis)		
Shoulder (e.g. disloc GH, Rot Cuff lesion, instability)		
Elbow (e.g. epicondylitis, olceranon bursitis)		

Wrist (e.g. Ulnar disc, dislocated lunate)		
Hand (e.g. Dupuytren's, FDP repair, Ulnar lig sprain)		
T-Spine (e.g. Scoliosis, disc lesion)		
L-spine (e.g. Strain, Spondylolithesis, Disc lesion)		
Hip (e.g. THR, # hip, OA, trochanteric bursitis)		
Knee (e.g. TKR, OA, Meniscal tear, Patellofem Syn, Lig Instability)		
Ankle (e.g. Lat lig sprain, Trimalleolar #)		
Foot (e.g. Plantar fasciitis, Hallux valgus)		
CVA/Stroke		
Traumatic Brain Injury		
Meningitis / Acute Infections		
Post-Surgical (e.g. spinal decompression, tumor)		
Cerebral Palsy		
Pediatric Neuromus conditions (e.g. Mus Dystrophy)		
Brachial Plexus injuries/syndromes		
Parkinson's Disease / Movement Disorders		
MS / ALS / GBS		
Developmental delay (e.g. hydrocephaly)		
Spinal Cord Injury (e.g. quadriplegia, paraplegia)		
Cerebellar Syndromes		
Amputations (e.g. transfemoral, transtibial)		
Burns		
Cancer (e.g. breast, lung, brain, leukemia)		
Complex Regional Pain Syndrome		
Dementia		
Diabetes		
Fibromyalgia		

Osteoporosis		
Pelvic Floor conditions (e.g. stress incontinence)		
Peripheral Nerve Injuries or Neuropathies		
Rheumatic Diseases (e.g. RA, SLE, Anky Spon)		
Transplants (e.g. heart, liver, lung, kidney)		
Wounds (e.g. ulcer)		

B. Assessment Procedures Checklist

Instructions: Keep track of the types of assessments that you observe or perform during your placements by a √ in the 'O' (observed) or the 'P' (performed) column. The procedures are not listed in a specific order. Provide comments if necessary. Procedures not on the list can added at the end.

Example:

Assessment Procedures	O	P	Comments/Details
History Taking	√	√	Observed CI with CF client, performed history with COPD client
Peripheral Joint Assessments	√	√	Performed on clients withTotal Shd, # Hip, Knee Meniscus, Olecranon Bursitis, Rot Cuff
Balance / Coordination Tests (e.g. Berg)		√	Did Berg with 2 PD clients

Assessment Procedures	O	P	Comments/Details
Chart Review			
History Taking			
Subjective Findings			
Lab Tests/Diag Imaging review (e.g. xrays, ABGs)			
Cognitive Evaluation (e.g. Oriented to P/P/T)			
General Appearance / Posture			
Vitals (e.g. HR, RR, BP, O2 Saturation)			
Circulation (e.g. color, peripheral pulses)			
Mechanical Ventilation Parameters			
General Function (e.g. bed mobility / sitting / sit to st etc)			
Inflammation / Joint effusion			
Reflexes (DTR, Babinski)			
Sensation (e.g. hot/cold, pinprick, light touch)			
ROM – AROM & PROM (e.g. goniometry)			
Manual Muscle Tests			
Gait / Ambulation(e.g. pattern, gait aids)			
Cranial Nerves Tests			

Neural Tension Tests (e.g. SLR, Slump, ULTTs)			
Balance / Coordination Tests (e.g. Berg)			
Fall Risk Assessment			
Pain Rating Scales (e.g. VAS, McGill)			
Functional Outcome Measures (e.g. FIM)			
Quality of Life Measures (e.g. SIP, SF-36)			
Endurance Measures (e.g. 6 min walk)			
IPPA (Inspection, Palpation, Percussion, Auscultation)			
Cardiac Auscultation			
U/E Scan / C Spine Clearing Tests			
L/E Scan			
Spinal Assessments			
Peripheral Joint Assessments			
Neurological Assessment (e.g. Stroke, PD)			
Pediatric Assessment (e.g. Developmental, School)			
Homecare Assessment (e.g. environmental scan)			
Pelvic Floor Assessments			

C. Treatment Interventions Checklist

Instructions: As with assessment procedures, keep track of the types of treatment interventions that you observe or perform during your placements by a √ in the 'O' (observed) or the 'P' (performed) column. The interventions are not listed in a specific order. Provide comments. Interventions not on the list can added at the end.

Example:

Treatment Interventions	O	P	Comments/Details
Suctioning (e.g. oral, nasophary, endo or trach)	√	√	Trached and intubated ICU pts
Prosthetic Training	√	√	Worked with Bilat Trans-tibial amputee
Pelvic Floor Therapy Techniques	√		Observed treatment session for Stress Incontinence

Treatment Interventions	O	P	Comments/Details
Positioning (for relaxation, V/Q matching, etc)			
PROM / Stretching Program			
General Mobility (e.g. Bed Mobility / Sit to Stand)			
Postural Drainage			
Autogenic Drainage			
Active Cycle Breathing			
Percussions / Vibrations			
Supported Coughing			
Suctioning (e.g. oral, nasophary, endo or trach)			
Transfers			
Ambulation / Gait Retraining			
Gait Aids (e.g. Crutchwalking on level / stairs)			
W/C management / fitting			
Postural Correction / Retraining			
Stability training (e.g. stable base, muscle synergy ex)			
Active Exercise Program (e.g. Autoassist, free ex)			
Resisted Exercise / PRE (e.g. PNF, Tubing, Weights)			

Ther Ex Home Program Design (Individual client)			
Neurofacilitation Techniques (e.g. func mat sequence)			
Constraint-induced Therapy			
Tilt table activities			
Hydrotherapy (e.g. Pool ex class, whirlpool)			
Soft Tissue Techniques (e.g. Frictions)			
Muscle Energy/Muscle mobilization techniques			
Peripheral Joint Play/Mobilization techniques			
Spinal Joint Play/Mobilization techniques			
Traction (e.g. manual, mechanical)			
Prosthetic Training			
Burn Care			
Wound Care (e.g. debride, high freq, vacuum-assist)			
EPA (U/S, NMES, TNS, IFC, Laser)			
Ice / Contrast Bath / Hot Packs			
Wax / Jobst / Biofeedback			
Pelvic Floor Therapy Techniques			
Cognitive Exercises			
Facial Exercises			
Discharge Planning / Consultation			
Family Conference			
Client Education – Individual or Family			
Client Education – Class (e.g. Osteoporosis)			
Community Wellness Programs			
Ordering Equipment (e.g. walker, W/C)			