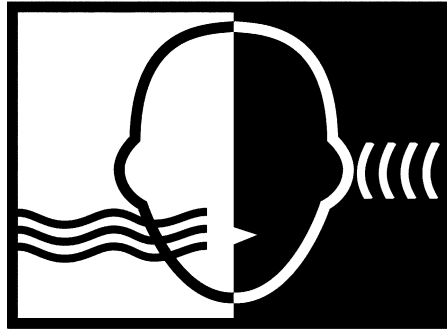


**C A S L P O**



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# **SELF ASSESSMENT GUIDE**

**JANUARY 2011**

**SELF ASSESSMENT GUIDE**  
 January 2011

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## 1. INTRODUCTION

The Self Assessment Tool is the culmination of the work of the Quality Assurance Committee. It was originally developed through extensive consultation with the membership through four pilot studies and numerous presentations. It has been used for the last three years and evaluated<sup>1</sup>. The results of the evaluation have been incorporated into this version of the Tool.

The purpose of this Guide is to provide members with assistance in completing the Self Assessment Tool. The Self Assessment Tool is one component of the Quality Assurance Program. The Self Assessment Tool is designed as a self-reflective instrument to allow members to evaluate their practices against the standards of the profession.

## 2. COMPONENTS OF THE SELF ASSESSMENT TOOL:

The Self Assessment Tool consists of the following components:

**Identifying Information:** Member must provide name and registration number. The date provided should be the date that the Tool was initially completed.

**Part I: Practice Description** Member is given the opportunity to describe their practice setting. This may be copied for multiple practice settings. Additional pages may be added.

**Part II: Professional Practice Standards** Member rates compliance with standards.

**Part III: Continuous Learning Activity Credit Program** Member identifies learning opportunities.

SECTION	FREQUENCY	REQUIREMENTS	SUBMISSION
Practice Description	Once every three years (more often if practice changes dramatically)	Member must keep for three years following the completion of a Self Assessment Cycle.	Member keeps in personal file to be made available to CASLPO on request.
Professional Practice Standards	Once every three years	Member must keep for three years following the completion of a Self Assessment Cycle.	Member keeps in personal file to be made available to CASLPO on request
Continuous Learning Activity Credit Program	<ul style="list-style-type: none"> <li>• Set initial Learning Goals in year 1.</li> <li>• Review and revise Learning Goals and Impact on Practice annually</li> <li>• Record Continuous Learning Activity Credits (CLACs) annually</li> </ul>	Member must keep each review on file for 6 years until a new Self Assessment Cycle is completed.	Member keeps in personal file to be made available to CASLPO on request

<sup>1</sup> Self Assessment Tool: Analysis of the First Three-Year Cycle *CASLPO Today* Issue 4, November 2004, 25-29

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Members are required to complete a Self Assessment Tool once every three years. The Continuous Learning Activity section is to be reviewed on an annual basis. These requirements must be met in order for members to maintain registration with the College. Members are expected to complete the Self Assessment Tool as soon as it is received. All documentation must be kept for 6 years, thus members should always have one completed Self Assessment Tool and supporting documentation on file if they have been members of the College for 3 years or more.

Members are required to retain their completed Self Assessment Tool. Each year a number of members will be randomly selected for an audit of their Self Assessment Tool. These members will be asked to submit their Self Assessment Tool to CASLPO for review. CASLPO will review the information in order to collect aggregate data. Self Assessment Tools will be screened for completeness but **will not be individually assessed**.

When requested by the College to submit their Self Assessment Tool, failure to do so could result in a referral to the Inquiries, Complaints and Reports Committee for professional misconduct. Depending on the circumstances the Committee may recommend that the Registrar place terms, conditions or limitations on a member's certificate of registration.

**Members who do nonclinical related work and academic members** may be part of the 250 random member submissions and will be required to submit their Self Assessment Tool and Continuous Learning Activities if selected. The compliance ratings on the Self Assessment Tools may be largely non applicable but these members will still be required to select Learning Goals and acquire 45 CLACs during the course of 3 years. In these cases the Learning Goals will relate to the member's major responsibilities in their positions.

For example, a member whose primary responsibility is administration will set learning goals and choose learning activities which will enhance their administration skills. An academic member may choose learning goals in their area of expertise as well as goals which may enhance teaching and research skills.

**Relationship of Self Assessment to Peer Assessment**

The Self Assessment Tool is a self-reflective tool, designed to allow members to consider and evaluate their practices. It is to be used by members to identify learning goals. When members are randomly selected to submit their Self Assessment Tools, CASLPO uses this information to evaluate the Tool and the program, not to evaluate individual members. The Peer Assessment Program is the evaluative component of the Quality Assurance Program. In order to show that members are practicing according to the standards of the profession, members will be asked to provide documentation of their compliance with the Professional Practice Standards when they are randomly selected for Peer Assessment. In this way, the Self Assessment Tool is the basis for Peer Assessment. Members who do nonclinical related work and academic members are not eligible for Peer Assessment.

### 3. DEVELOPMENT OF THE SELF ASSESSMENT TOOL

The Self Assessment Tool is a part of the Quality Assurance Program. The Regulated Health Professions Act (RHPA), 1991, requires each college established under the Act to define and implement a program to assure the quality of the practice of the profession and to promote continuing competence among its members.

The underlying philosophy of the Quality Assurance Program is consistent with the notion of continuous quality improvement, which encourages the continuous pursuit of quality practice. The Self Assessment Tool provides members with the mechanism to self evaluate their practices in relation to the Professional Practice Standards. This allows members to engage in the ongoing pursuit of quality practice. The Self Assessment Tool is the cornerstone of the Quality Assurance Program of the College.

Professional Practice Standards are at the heart of the Quality Assurance Program. These Standards define quality practice and articulate the public's expectation when receiving service from audiologists and speech-language pathologists. They were developed utilizing the key elements of the Regulated Health Professions Act, CASLPO regulations, Code of Ethics, Position Statements and Preferred Practice Guidelines. The background to the standards development and the primary ways in which they will be used are illustrated on the below:

#### Professional Practice Standards

The five Professional Practice Standards are fundamental to competent audiology and speech-language pathology practice. Meeting these standards ensures that the member is fulfilling the requirements to practice audiology and speech-language pathology. They are listed below:

1. **Management Practice** - Audiologists and speech-language pathologists manage their practice in an accountable manner.
2. **Clinical Practice** - Audiologists and speech-language pathologists possess and continually acquire and use the knowledge and skills necessary to provide high quality clinical services within their scope of practice.
3. **Patient/Client Centred Practice** - Audiologists and speech-language pathologists ensure that their patients/clients are treated with respect and are provided with sufficient information and opportunities to make informed decisions regarding intervention. In making clinical decisions, the patient/client's interests should be primary.
4. **Communication** - Audiologists and speech-language pathologists communicate effectively and with sensitivity to the needs of their patients/clients.
5. **Professional Accountability** – Audiologists and speech-language pathologists are accountable and comply with legislation.

Each of the standards is defined by behavioural indicators, which are the basis of the Self Assessment Tool. These are to be used by the member to determine compliance with standards and assist the member in determining learning goals which are relevant to the development of

compliant practices. Examples of compliance are listed to assist members in evaluating how they comply with the behavioural indicators. The member may choose the one example that best illustrates compliance with the indicator or provide another example in the line labelled “Other”. The given examples are not intended to be an exhaustive list nor does the member have to have evidence for each of the examples listed in every case. Be creative when applying the indicators to your practice. CASLPO encourages flexibility and innovation when determining how to demonstrate compliance with the standards.

### **Definitions**

Terms used in the Professional Practice Standards have been defined below.

#### **CONSULT**

To consult with a patient/client encompasses any type of communication with a patient/client regarding the clinical intervention. While this would include face-to-face communication, it could also include telephone conversations, written communication or information given through any other individual in a multidisciplinary setting. In instances where the patient/client does not respond, the act of forwarding the information will constitute an attempt at consultation.

#### **EVIDENCED-BASED PRACTICES**

Practices for which there is empirical evidence that the practice is effective.

#### **INTERVENTION**

Intervention is used in this context to include any patient/client contact in the clinical context, including but not limited to screening, assessment, treatment and management.

#### **INTERVENTION GOALS**

Intervention goals refer to the expected outcome of any type of clinical activity. These goals need to be addressed from the perspective of the patient/client.

#### **INTERVENTION PLAN**

An intervention plan refers to any type of clinical activity, which the member intends to engage in with the patient/client. This could include a proposed set of assessment techniques, a specific test or test battery, a therapy plan, goals (long-term or short-term) for therapy, the intention to provide a device or strategies to enhance function, referral to another professional, or any other proposal for clinical activity.

#### **PATIENT/CLIENT**

Patient/client refers to the individual receiving the service. Where appropriate, the patient/client may also encompass family, significant others, caregivers, teachers, etc.

#### **PATIENT/CLIENT CENTRED CARE**

Patient/Client Centred Care refers to care which is driven as much as possible, by the patient/client’s perspective. Patient/Client Centred Care would also include the family, significant others and the patient/client’s environment where care would be enhanced by such inclusion or when the patient/client specifically requests such inclusions.

#### 4. HOW TO COMPLETE THE SELF ASSESSMENT TOOL

##### I. PRACTICE DESCRIPTION

All self-assessments begin with an opportunity to describe the practice setting. This section is designed to assist members in taking an objective view of their practice within the context of the environment in which they work. Members will check off all information relevant to the individual practice and setting. Any additional information may be provided in the Practice Narrative and Practice Challenges portions of Section 7, Practice Context.

**The Practice Narrative** is meant to define the caseload. Members should include information about their clinical activities and their practice setting. Members may also provide any other information, which may be relevant such as mode of service delivery and relevant funding models (e.g. school aged children seen in classroom within a consultative framework or neurologically impaired adults seen in the community through CCAC, length and frequency of treatment determined by CCAC criteria, etc.).

**The Practice Challenges** section allows members to identify systemic constraints, which may be beyond the member's control, and outline how these constraints are managed while attempting to meet patient/client needs. Members are encouraged to provide as much information as deemed useful and are not to be constrained by the available space. Add extra pages as necessary.

##### II. PROFESSIONAL PRACTICE STANDARDS

This portion of the Tool is designed to measure compliance with the Professional Practice Standards. The Tool consists of the five Professional Practice Standards (listed on page 5). Professional Practice Standards 1-4 are followed by four or five behavioural indicators, which have been chosen to reflect the standard. (For example, Professional Practice Standard 1: **Management Practice** - Audiologists and speech-language pathologists manage their practice in an accountable manner. **Indicator 1.1:** I have criteria to begin and end intervention.)

##### How to Rate Compliance

Members are required to rate their level of compliance on each of the behavioural indicators. Each of the indicators is followed by a number of examples of evidence of compliance. In most cases, members need only be compliant with one of the examples, to be compliant with the indicator. In rating your level of compliance, assess whether you meet each of the behavioural indicators by checking the box that best reflects your level of compliance **at this point in time**. If an indicator does not apply to your practice you would check "Non Applicable" and include your explanation on the line below.

LEVEL OF SELF ASSESSED COMPLIANCE:

COMPLIANT <input type="checkbox"/>	* PARTIALLY COMPLIANT <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	*NON COMPLIANT <input type="checkbox"/>	NON APPLICABLE <input type="checkbox"/>
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If not applicable, explain:

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\*If partially or non compliant include learning goal.

To determine your level of compliance, use your best professional judgement based on what you believe would be a fair and objective assessment of your practice. To determine what a fair and objective assessment is, consider what a reasonably diligent audiologist or speech-language pathologist would do in similar circumstances. This is sometimes referred to as the concept of due diligence. Members should use this concept when evaluating their practices.

**Compliant** should be checked off when a member is in full compliance with that indicator all of the time. This would reflect a full understanding of the indicator and consistent application of the behaviour in practice.

**Partially Compliant** should be checked off when a member is in compliance with that indicator part of the time or where the level of compliance does not reflect full compliance. Such a rating would reflect an understanding of the indicator but only inconsistent application of the behaviour in practice.

Note that there are 3 levels of partial compliance. Members are asked to judge the degree of compliance in relation to being totally compliant or non compliant. If the level of partial compliance were close to but not exactly totally compliant, then the member would check the box under partial compliance furthest to the left. If the level of partial compliance were almost non compliant, then the member would check the box furthest to the right. If the level of partial compliance falls in the middle of compliant and non compliant, then the member would check off the box in the middle.

**Non Compliant** should be checked off when a member is not in compliance with that indicator. Such a rating would reflect a lack of understanding of the indicator and no application of the behaviour in practice. Such a rating should signal to the member that this is an area which requires both education and the need to incorporate the behaviour in practice. This should not be viewed as punitive but as an opportunity to improve compliance with the standards of the professions. Members should be encouraged to be honest in rating compliance.

A member engages in self-assessment for the primary purpose of self-evaluation. Self-assessment is meant to be a reflective exercise in order to identify learning goals. In fact, when a member has self rated an indicator as partially or non compliant, then there must be a learning goal which leads to greater compliance on the behaviour or skill referenced in the indicator. It is a requirement of the Continuous Learning Activity Program that members have a learning goal for all indicators that are rated as partially or non compliant.

Members will not be individually evaluated on their Self Assessment Tools. The information derived from the Self Assessment is for the member only. CASLPO will ask randomly selected members to submit Self Assessment Tools in order to collect aggregate data. The only exception to this is when members are randomly selected for peer review. At that time, the selected members are required to submit their Self Assessment Tools with evidence of compliance. It is during a peer assessment that the member's compliance is evaluated.

On peer assessment when a member has a rating of partial or non compliance on a specific indicator, the peer assessor will assess whether the proposed learning goal addresses the area of

partial or non compliance. Normally, in the context of a competent practice with the member demonstrating good insight into strengths and weaknesses, a plan in place to address deficiencies, and practices which hold the patients/clients interests as paramount, an occasional rating of non compliance would be utilized as a starting point to develop practices which would be compliant. The purpose of self-assessment is to assist the member and the College to improve clinical service delivery in the public's interest.

### Examples of Evidence of Compliance

In the Self Assessment Tool each behavioural indicator is followed by examples of compliance. These are to be used to assist in understanding what each behavioural indicator is meant to evaluate. The examples are listed as possible samples and are not meant to be an exhaustive list. Members are to feel free to supply their own examples of compliance based on their practices. Use the space in the "Other" category to add any other examples, which are being used to evaluate compliance. For some indicators, compliance with any **one example** (whether from the Guide or devised by the member) would be sufficient. For others, certain examples of compliance are required. (See Indicator 1.2 "I maintain records, which accurately reflect the services provided." for an example of an indicator where all the examples of compliance are required to be consistent with the Proposed Regulation for Records.) However, when submitting evidence of compliance for Peer Assessment, only **one example** of evidence is required to be submitted.

Examples of compliance can come from any number of sources. Members are urged to be creative when choosing and documenting evidence of compliance. The examples should truly reflect a member's practice, thus the use of flexibility and resourcefulness will assist the member. Some common sources include correspondence such as memos and email, minutes from meetings, organization standards, testimony of peers, performance appraisals, interdisciplinary protocols and article collections. Members should not feel limited by these examples. Innovation and imagination are encouraged. It is also important to remember that only **one example** of evidence is required for each indicator when submitting evidence for Peer Assessment.

Members are encouraged to collect documentation of evidence of compliance. While this is not a mandatory aspect of the Self Assessment Tool, there are numerous advantages to cataloguing evidence of compliance as it becomes available.

The advantages of compiling evidence of compliance are to:

- Promote a more thorough understanding of the indicator;
- Alert the member to practice issues which might otherwise not be apparent;
- Provide documentation of quality in practice;
- Retain evidence which might not be kept routinely such as policy statements or communication within the practice setting with colleagues and administrators which describe rationale and documentation for certain practices;
- Assist the member in compiling evidence of compliance for Peer Assessment.

Members who work in group practices may want to collect evidence of compliance that pertains to the whole group such as institutional policies or joint service delivery planning and initiatives.

This group information could be available to individual members, if selected for Peer Assessment. In these cases members would be able to select from a number of options the one example of evidence of compliance to be submitted for Peer Assessment. Members are reminded that **one example** of evidence of compliance is all that is required for Peer Assessment.

Members may want to use Appendix III to assist in compiling a catalogue of evidence of compliance.

### **Creating Appropriate Learning Goals**

A member is always encouraged to derive learning goals that relate to indicators of the Self Assessment Tool. In cases, where the indicator has been rated partially or non compliant, the member **must** formulate a learning goal to address the compliance discrepancy. However, in the spirit of continuous quality improvement, members who are compliant with an indicator may wish to increase their knowledge in the area that the indicator reflects. In devising a learning goal, the member should reflect on what they need to learn in order to increase compliance with the indicator and then determine how they will learn that information.

### **Selecting Evidence of Compliance and Determining Learning Goals**

#### **1. MANAGEMENT PRACTICE**

**Audiologists and Speech-Language Pathologists manage their practice in an accountable manner.**

##### **1.1 I have criteria to begin and end intervention.**

###### **Evidence:**

Any type of evidence that suggests a decision making process for the commencement and completion of intervention may be provided. All records should have some reference for the rationale for beginning and completing intervention. This may be documented in policy but does not have to be. Such policies may include rationale for assigning priorities to groups of patients/clients to be seen or caseload constraints that exclude types of patients/clients from being seen.

In the case of a consultative practice or a practice, which primarily focuses on assessment, documentation of a recommendation for no further intervention would be an example of criteria to end intervention. In such a case, where further intervention is recommended, documentation of rationale could also be an example of compliance.

If further follow-up is indicated but it is at the discretion of the patient/client, this fact should also be documented. In cases where patient/client function is monitored for extended time periods, criteria for discharge may be at the patient/client's discretion and attendance at follow-up appointments is considered implied consent to continue intervention.

###### **Sample Learning Goals:**

To learn more about community resources that patients/clients may utilize on discharge in order to develop criteria to end intervention in the patient's/client's best interest.

To acquire knowledge of policy development to set admission criteria for intervention to ensure that all accepted patients/clients can be provided with service that meets their needs.

## 1.2 I maintain records, which accurately reflect the services provided.

### Evidence:

The following items must be included in all patient/client records (Proposed Regulation for Records Section 5 (2)):

- a. The patient's or client's name and address and phone number;
- b. The date of each of the patient's or client's visits with the member, unless this information is available from some other readily accessible source;
- c. The name of the referring source;
- d. Pertinent history of the patient or client or reference where this information may be found;
- e. Reasonable information about assessments and treatments performed by the member and reasonable information about significant clinical findings, diagnosis and recommendations made by the member;
- f. Reasonable information about significant recommendations made by the member for examinations, tests, consultations or treatments to be performed by any other person;
- g. Every written report received by the member with respect to examinations, test, consultations, or treatments performed by other professionals or a reference to where the reports are available;
- h. Reasonable information about advice given by the member and every pre-treatment or post-treatment instruction given by the member;
- i. Reasonable information about every controlled act within the meaning of subsection 27(2) of the Regulated Health Professions Act, 1991, performed by the member;
- j. Reasonable information about every delegation of a controlled act within the meaning of Subsection 27(2) of the *Regulated Health Professions Act 1991*, by the member including the name of the person to whom the act was delegated;
- k. Reasonable information about every referral of the patient or client by the member to another professional;
- l. Any reasons a patient or client may give for cancelling an appointment;
- m. Reasonable information about every **relevant and material service activity** that was commenced but not completed, including reasons for the non-completion;
- n. A copy of every written consent related to the member's service to the patient or client.

The following item must be included in all patient/client records (Proposed Regulation for Records Section 2):

Each member shall maintain a system that records the date of each contact with a patient or client whom the member assesses or treats.

The following item must be included in all patient/client records where the member bills the client directly or through a third party (Proposed Regulation for Records Section 4 (2)):

The financial record must contain the following information concerning the services performed and the amount billed:

- a. The recipient of the services;
- b. The provider of the services;
- c. The date the services were performed;
- d. The nature of the services performed;
- e. The unit fee for the services;
- f. The total charge for the services;
- g. Whether payment has been received for the services;
- h. The date and source of the payment.

In determining compliance with this indicator the checklists in Appendices I and II of the Self Assessment Tool may be utilized. Each column in the checklist can be coded to refer back to a specific patient/client record. These are for member use only and are not required for submission to the College, in the event that the member is randomly selected to submit the Self Assessment Tool.

**Sample Learning Goals:**

To further knowledge of the College's record keeping requirements by reviewing College publications to ensure that documentation practices are compliant.

To learn more about the documentation practices of colleagues in different practice settings to determine ways to improve record keeping and ensure on-going compliance with CASLPO standards.

**1.3 I perform controlled acts according to Preferred Practice Guidelines and Position Statements.**

**Evidence:**

Controlled acts are the 13 restricted acts defined in Section 27 of the RHPA. When audiologists perform the controlled act for hearing aid prescription the relevant Preferred Practice Guideline must be followed. (Prescription of Hearing Aids to Adults, 2000, Prescription of Hearing Aids to Children, 2002). This controlled act must not be delegated according to the Position Statement on Delegation of the Controlled Act of Prescribing a Hearing Aid for a Hearing Impaired Person 2000. In addition, if an audiologist changes a hearing aid prescription the Position Statement on Changing Hearing Aid Prescriptions, 2000, must be followed.

When speech-language pathologists or audiologists accept delegation of controlled acts then the requirements set out in the Position Statement Acceptance of Delegation of a Controlled Act 2000 must be met.

If the member does not perform controlled acts or delegated controlled acts, the Non Applicable category would apply.

**Sample Learning Goals:**

To acquire knowledge about current practices for hearing aid prescription to apply in practice in order to ensure that CASLPO standards and guidelines are met.

To gain mentorship by colleagues who have been delegated the management of tracheoesophageal voice prostheses to ensure that all the requirements of accepting delegation of a controlled act are met.

#### **1.4 I am accountable for unregulated personnel providing intervention under my direction.**

##### **Evidence:**

This indicator is not meant to apply to situations where the member may work in the same environment with unregulated personnel who do not provide audiology or speech-language pathology services (such as in the case of rehabilitation aids or teachers' aides.) Note that where audiology or speech-language pathology services are provided by unregulated personnel, this must be done under the supervision of the member. This indicator is also not meant to apply to family members assisting a patient/client with a home program or providing general stimulation and conversational support.

This indicator is intended to apply to the situations where members choose to use unregulated personnel to augment the intervention they provide or in situations where a member is supervising audiology or speech-language pathology students. In such instances the service provided by the unregulated personnel would be the ultimate responsibility of the member. This would include but not be limited to audiology and speech-language pathology students and supportive personnel. In these instances the requirements outlined in the Position Statements Guidelines for the Use of Supportive Personnel, 1997, and Supervision of Students of Audiology and Speech-Language Pathology, 2002, would need to be met.

##### **Sample Learning Goals:**

To learn more about communication and feedback skills to provide effective supervision of supportive personnel.

To acquire knowledge of efficient time management skills in order to provide appropriate student supervision and manage caseload demands.

#### **1.5 I ensure that all materials and equipment used in my practice are in working order and calibrated as required.**

##### **Evidence:**

This indicator is meant to encompass any materials and/or equipment used in intervention. It would include assessment batteries and therapy materials particularly those tests and therapy programs which include numerous parts or pieces as well as audio tape and video tape recorders and equipment which requires calibration. The purpose of this indicator is to ensure that all the required materials are readily accessible for clinical use and that the required parts are not broken or unusable. Where calibration is required it should be based on the most current applicable standards.

**Sample Learning Goals:**

To further knowledge of calibration requirements in order to ensure that the equipment used in my practice meets CASLPO and international standards.

To learn about protocols for equipment maintenance from colleagues with similar practices in different practice environments.

**1.6 I follow health and safety procedures and practices.**

**Evidence:**

The member is required to show awareness and implementation of policies to ensure a safe practice environment for patients/clients, members and any staff a member may supervise or employ. Evidence of the application of infection control procedures specific to the practice environment which include a hand washing protocol would meet the requirement. Guidelines that determine use of gloves, disinfection of equipment, materials and clinical space with rationale may also demonstrate compliance. Safety procedures could consist of ensuring safe entrance to the practice environment in inclement weather.

**Sample Learning Goals:**

To improve my knowledge of infection control procedures in my practice setting by attending available education sessions and consulting with infection control staff.

To acquire knowledge of infection control standards and procedures by reviewing on line resources.

## **2. CLINICAL PRACTICE**

**Audiologists and Speech-Language Pathologists possess and continually acquire and use the knowledge and skills necessary to provide high quality clinical services within their scope of practice.**

### **2.1 I practice within the limits of my individual competence.**

#### **Evidence:**

This indicator allows the member to demonstrate how competence is maintained in the face of developing professional knowledge and challenges encountered in the practice environment. Challenging situations may include being assigned an unfamiliar caseload or managing large caseloads. The member would demonstrate compliance by making efforts to gain the competence or increase efficiency by self-study or by arranging formal/informal mentorship opportunities. Examples of compliance could include comments on these skills in a performance appraisal, documentation of time management skills, notes of contact with experienced members or documentation of discussions with the employer or funder.

#### **Sample Learning Goals:**

To learn more about techniques and strategies to incorporate into clinical practice in order to improve my treatment of children with autism.

To further knowledge of caseload management strategies to increase efficiency yet meet patient/client needs.

### **2.2 I continually acquire knowledge and skills necessary to provide high quality service.**

#### **Evidence:**

Compliance with this indicator would be documentation of an up-to-date Continuing Learning Activity program. A member would need to show that at least three Learning Goals have been identified per year and the associated learning activities. The member might want to show how learning activities relate to learning goals and how learning goals relate to practice. This might also be an opportunity for the member to explain the progress and impact on practice statements.

#### **Sample Learning Goals:**

To continue learning and refining skills in promoting preliteracy skills in preschool children.

To gain more knowledge in treatment of patients/clients with tinnitus by reviewing the literature on treatment approaches and applying and evaluating these approaches in therapy.

### **2.3 I utilize intervention procedures based on current knowledge in the fields of audiology and/or speech language pathology, consideration of advances in technology and available evidence-based techniques.**

#### **Evidence:**

The member is expected to show that the methods employed in practice have validity. Documented rationale for non-standard procedures would be evidence that there are many

instances where evidence-based techniques have not been established, yet sound clinical judgement would dictate the chosen course of action. It is recognized that only a small percentage of clinical techniques are evidence-based. Members are encouraged to be aware of those techniques as well as collecting their own evidence for techniques, which they believe to be effective. In the absence of evidence-based techniques, members should rely on accepted practices or common professional knowledge. Evidence of professional consultation with other colleagues would be a type of example of compliance. This could take the form of consultation as challenges arise or routine discussions such as regular professional meetings devoted to improving service delivery. Further, evidence of consideration and knowledge of current technology for intervention may take the form of recently updated equipment, use of a variety of technology, etc.

**Sample Learning Goals:**

To continue to acquire knowledge of evidence-based practice in hearing aid prescription in order to provide quality service to the hearing impaired individuals in my practice.

To learn more about assessment and therapy goal setting and how colleagues measure outcomes and apply this data to practice.

**2.4I utilize intervention procedures that are appropriate to the patient/client's abilities.**

**Evidence:**

The purpose of this indicator is to allow the member to demonstrate sensitivity to the challenges and potential barriers a patient/client may face in the course of receiving clinical service from a member. The focus is on utilization of intervention techniques, which will support the formulation of realistic goals and expectations for the intervention (to be contrasted to the communication techniques referred to in indicator 4.2).

In addition if members choose to use specialized techniques of delivering service (such as Telepractice) or techniques which may not be widely accepted (such as alternative approaches to intervention), they must be prepared to provide justification which supports the use of such techniques in the context of the needs and wishes of the patient/client.

**Sample Learning Goals:**

To continue to expand my knowledge about new technology and advances in hearing aid performance to provide patient's/client's with appropriate and effective amplification options.

To increase knowledge of available assessment tools to ensure that patient's/client's receive a meaningful evaluation of their language skills.

**2.5 I utilize intervention procedures that are appropriate to the cultural/linguistic background of the patient/client.**

**Evidence:**

Members are expected to adhere to the Position Statement, Service Delivery to Culturally and Linguistically Diverse Populations. This indicator provides an opportunity to demonstrate how

these principles are incorporated into the member's practice. The focus of this indicator is on integrating cultural and linguistic sensitivity into intervention techniques and to be sensitive to differences in social interaction (to be contrasted with the communication techniques referred to in indicator 4.3).

Members are encouraged to look beyond the obvious signs of cultural and linguistic diversity and recognize that while cultural differences may be subtle they may have a significant impact on how a patient/client and their circle of support view impairment and rehabilitation. Members are reminded that even though patient/clients may speak the same language, their cultural background may have a significant impact on how the member approaches their care. For example, some cultures may:

- Require that the member be of the same sex as the patient/client;
- Dictate how hearing aids may be worn so as not to interfere with head coverings;
- Prohibit certain vocabulary items from being used in augmentative communication systems;
- Prohibit certain food items and/or require others.

Members should strive to be sensitive to linguistic and cultural issues, which may have an impact on the care they provide.

**Sample Learning Goals:**

To learn more about perception of hearing loss in children in the cultures represented in my practice.

To improve my knowledge of food preferences in different cultures to ensure the provision of culturally sensitive dysphagia management.

**2.6 I monitor, evaluate and modify my intervention procedures based on patient/client outcome.**

**Evidence:**

This indicator ensures that all patient/client interaction is adapted as necessary in order to maximize the patient/client's potential to achieve the goals of intervention. Compliance would be demonstrated by recording results of assessment and intervention and using these results as a rationale for decisions on how the intervention would proceed. Wherever possible and as required, objective verification and subjective validation should be obtained.

The intervention may be indirect on the patient/client's behalf such as in a consultative model of service delivery. Information may be gained from others involved with the patient/client if not directly from the patient/client.

The intervention may be limited to an assessment. Evidence of changes in assessment procedures or acknowledgement of the patient/client's expectations of outcome would be considered evidence of compliance.

**Sample Learning Goals:**

To acquire knowledge of clinical outcome measures to be utilized in determining when to discharge a patient/client.

To learn more about setting appropriate goals for my patients/clients by literature review and consultation with colleagues.

### **3. PATIENT/CLIENT CENTRED PRACTICE**

**Audiologists and Speech-Language Pathologists ensure that their patients/clients are treated with respect and are provided with sufficient information and opportunities to make informed decisions regarding intervention. In making clinical decisions, the patient/client's interests should be primary.**

#### **3.1 I obtain and document consent for all intervention.**

##### **Evidence:**

Patients/clients must always give informed consent to treatment according to the Health Care Consent Act. This indicator ensures adherence to the legislation and College requirements. While the patient/client is not required to sign a consent form, evidence that a discussion regarding informed consent to intervention needs to be documented.

CASLPO requires that members must obtain consent for screening, assessment and treatment as delineated in the Position Statement on Consent to Provide Screening and Assessment Services, 2007.

Particular attention must be paid when obtaining consent to provide novel or less commonly accepted intervention practices, as outlined in the Position Statement on Alternative Approaches to Intervention, 2002. Members must be sure to inform patient/clients of the novel or alternative nature of the approach and their rationale for selecting that approach. In these circumstances evidence of such a discussion would constitute evidence of compliance for this indicator.

##### **Sample Learning Goals:**

To continue to update knowledge of requirements for consent by reading CASLPO Today and sharing information with colleagues.

To acquire knowledge about the documentation requirements for consent discussions by reading Desk Reference and sharing information with study group.

#### **3.2 I obtain and document consent to collect, use, retain, disclose and discard personal health information.**

##### **Evidence:**

Patients/clients must always give informed consent for the collection and use of personal health information. This indicator ensures adherence to the Personal Health Information and Privacy Act (PHIPA). While the patient/client is not required to sign a consent form, evidence that information was provided on the handling of personal health information needs to be documented. This information may be provided in the privacy policy that is made available to patients/clients.

**Sample Learning Goals:**

To continue to update knowledge of requirements of PHIPA by reading CASLPO Today and reviewing the website of the Privacy Commissioner of Ontario.

To acquire knowledge about creating and updating my privacy policy by taking available courses, consulting with colleagues and reviewing CASLPO and legislative requirements..

**3.3 I consult with a patient/client when establishing an intervention plan.**

**Evidence:**

The hallmark of patient/client centred care is involvement of the patient/client in all aspects of clinical decision-making. If the intervention consists exclusively of assessment, consultation with the patient/client could consist of a review of the assessment procedures, a discussion of the type of expected results, consideration of how the results will determine a further course of action or outlining how the results will answer the questions that motivated the assessment. Any type of documentation of this discussion or evidence that it occurred would be considered evidence of compliance

Members must ensure that consultation with patient/clients occurs in all instances of intervention. This includes reviewing surveillance material as part of an assessment. The Position Statement on the Use of Surveillance Material in Assessment requires that members advise the patient/client of the existence of the material and give them an opportunity to comment on its content. Documentation of adherence to this Position Statement would constitute evidence of compliance for this indicator.

**Sample Learning Goals:**

To acquire knowledge about effective strategies to engage patients/clients in discussions about treatment options.

To further knowledge about the type of information and format of presentation patients/clients prefer in order to understand their intervention choices.

**3.4 I set intervention goals that describe realistic outcomes for patients/clients.**

**Evidence:**

The purpose of this indicator is to ensure that all intervention is appropriate for the patient/client. This requires on-going counselling with the patient/client the intervention process. This would apply even if the intervention consisted of assessment only or consultation. This may involve collaboration with others involved with the care of the patient/client exclusively or in conjunction with the patient/client where consent for such collaboration is provide.

**Sample Learning Goals:**

To gain more knowledge about the literature in outcome measures to determine what are reasonable expectations for progress in therapy for the patients/clients on my caseload.

To learn more about goal setting and revising goals based on patient/client performance to ensure appropriate expectations regarding progress and outcome.

### **3.5 I respect each patient/client's decision to decline intervention.**

#### **Evidence:**

In the provision of patient/client centred care it is important to be sensitive to the patient/client's reaction to the intervention, even if the patient/client is unable to clearly express thoughts and opinions. Patients/clients may find it difficult to decline or end intervention and thus may express their intention in subtle ways. This may be more prevalent in instances where the patient/client's opinion differs from that of the member. Evidence that the member has taken into account the patient/client's perspective, regardless of the method of how this is expressed would be considered compliance.

#### **Sample Learning Goals:**

To further knowledge of patient/client reasoning underlying refusal to continue therapy in order to support these decisions.

To continue to learn about how to anticipate a patient's/client's decision to decline intervention by reviewing literature and blogs written by patients/clients of their experiences in treatment.

### **3.6 I maintain patient/client confidentiality at all times.**

#### **Evidence:**

The maintenance of confidentiality is the basis of trust between the patient/client and the member. This requires respect and vigilance in order for the service provided by the member to have credibility and be effective. Members are expected to be compliant with the Personal Health Information Protection Act, which requires:

- Written statement available to the public, which describes health information practices how to reach a contact person, information regarding access and correction of the health record and how to complain regarding personal health information;
- Documentation of implied or express consent as appropriate to release personal health information;
- Evidence of discussion regarding uses and disclosures of personal health information without consent.

When clinical information is released, there must be documentation to support the patient/client's consent to the release of information. The development of a culture, which shows a high regard for patient/client confidentiality, is encouraged. This would entail for example, not having conversations relating patient/client information in public, carrying material to conceal any identifying information and storing clinical information where only appropriate access is possible. Any type of evidence to support these attitudes would be considered good practice.

#### **Sample Learning Goals:**

To learn more about procedures to support confidentiality by reviewing decisions on the website of the Information and Privacy Commissioner.

To acquire further knowledge about procedures for managing patient/client information when providing treatment in the community and working with colleagues to find ways to increase the protection of this information.

#### **4. COMMUNICATION**

**Audiologists and Speech-Language Pathologists communicate effectively and with sensitivity to the needs of their patients/clients.**

##### **4.1 I communicate in a manner that facilitates patient/client comprehension and participation.**

**Evidence:**

The therapeutic relationship between a member and a patient/client is predicated on effective, responsive and sensitive communication skills. The nature of communication is a crucial component to any intervention provided. As communication professionals, CASLPO members have an obligation to assist and enhance patient/client communication within the therapeutic environment. This obligation extends to substitute decision-makers and others involved in the patient/client's care. Any evidence, which demonstrates an understanding of this obligation and utilization of strategies to enhance communication, would be considered compliance.

**Sample Learning Goals:**

To continue to read and take courses in effective communication techniques.

To further knowledge of what supports patients/clients require when processing information under stress or when disappointed with results.

##### **4.2 I use language that is appropriate to the age and cognitive abilities of the patient/client.**

**Evidence:**

This indicator refers to using communication techniques, which take into account the patient/client's communicative abilities (in contrast with 2.4 which refers to appropriate intervention techniques.) As with all references to patient/client, this also incorporates substitute decision-makers as appropriate (e.g. parents in the case of a young child or child in the case of a cognitively impaired parent.) Thus this indicator would apply to the interaction with those involved with the patient/client. Compliance with this indicator may also include accommodations made to minimize sensory or physical barriers to communication (such as providing material in large print for the elderly or choosing a seating position for the patient/client which maximizes interaction).

**Sample Learning Goals:**

To increase knowledge by reviewing the literature on the use of pictures, graphics and other visual aids to assist nonverbal patients/clients in comprehension skills.

To expand knowledge of the comprehension development of children to use in the creation of easily understood handouts to explain common communication disorders to a paediatric population.

#### **4.3 I use language that is appropriate to the linguistic and cultural background of the patient/client.**

##### **Evidence:**

The purpose of this indicator is to ensure that members use communication which is consistent with the Position Statement Service Delivery to Culturally and Linguistically Diverse Populations. The focus is on communicating with sensitivity to cultural and linguistic issues (to be contrasted with incorporating these principles into intervention techniques as outlined in indicator 2.5). While use of an informant is preferred practice, it is recognized that this is not always possible due to constraints beyond a member's control. In such a situation the member would demonstrate strategies to address the cultural and or linguistic diversity of patients/clients using available resources.

##### **Sample Learning Goals:**

To continue to learn about effective use of interpreter services by working with the interpreters in my facility to ensure that their services are maximized during assessment sessions.

To further knowledge of nonverbal communication techniques to utilize where interpreter services cannot be found to assist with patient/client treatment.

#### **4.4 I communicate constructively, effectively and collaboratively with my peers/team/co-workers, including members of other professions**

##### **Evidence:**

The best interests of the patient/client are served when professionals work together and maintain positive professional relationships. This indicator provides members with the opportunity to demonstrate their abilities as productive team members. This applies to sole practitioners as well as those based in multidisciplinary practice environments, as preferred patient/client care must always involve constructive interaction with others. When two members are both providing clinical service to a patient/client, the Position Statement on Concurrent Intervention by CASLPO Members, 2001 must be followed. Members must adhere to the Position Statement on Resolving Disagreements Between Service Providers, 2006 in cases where professionals disagree about patient/client care.

##### **Sample Learning Goals:**

To learn more about team dynamics to ensure my effective participation as an interdisciplinary team member.

To acquire knowledge of communication techniques to diffuse conflict.

#### **4.5 I accurately communicate my professional credentials, to my patients/clients and others.**

##### **Evidence:**

Members should take advantage of opportunities to interact with the public to advocate for the professions as well as promoting individual practices. However, in doing so, members must ensure that the information communicated about the member and the member's practice is accurate. As well as being consistent with the Code of Ethics (Section 4.1), members should also consult the Proposed Regulation for Advertising, 1996, and Ontario Regulation 749/93: Professional Misconduct, 1993. In stating their titles, members must ensure that they are compliant with the Position Statement on Use of the Title "Doctor", 2003.

**Sample Learning Goals:**

To further knowledge of the College requirements to ensure that the information on my business cards meets College standards.

To learn more about how College requirements to ensure that the marketing materials for my private practice meet the College standards.

**5. PROFESSIONAL ACCOUNTABILITY**

**Audiologists and Speech-Language Pathologists are accountable and comply with legislation.**

**Evidence:**

I have knowledge of Regulations, Preferred Practice Guidelines, Position Statements, Code of Ethics and legislation relevant to my practice.

Members are expected to show knowledge of the Regulations, Preferred Practice Guidelines, Position Statements, Code of Ethics and relevant legislation. These documents form the foundation underlying the public protection mandate of CASLPO. In certain instances, not all these documents will apply to all practices.

**Members are expected to have reviewed all of the documents in the Desk Reference** as well as any legislation which is relevant to the member's practice area. Members should tick off documents as they have been reviewed and then determine if the documents are applicable to their practices by circling the appropriate response. In cases where any of the CASLPO documents do not apply to a practice, the member must be prepared to provide justification if requested. (Note when documents refer to one of our two professions, the document does not apply to the non-specified profession. For example the Preferred Practice Guideline for Dysphagia, would not apply to audiologists.)

All members are provided with a CASLPO Desk Reference. This is to be continually updated as more documents are released. There is also a virtual Desk Reference available on the CASLPO website [www.caslpo.com](http://www.caslpo.com). Members are not required to have a Desk Reference if they have access to the on line documents.

In the section: Add Other Documents as Developed, there is room to include documents that CASLPO releases after the Self Assessment Tool is published, as the Tool lasts for 3 years. This section should be updated on an annual basis.

Members are also required to review legislation relevant to their practices. The required legislation is listed in the Tool followed by space for the member to list what additional legislation is relevant to the individual practice. All legislation is available on the Government of Ontario web site [www.e-laws.gov.on.ca](http://www.e-laws.gov.on.ca).

**Sample Learning Goals:**

To learn more about recent CASLPO regulations and government legislation related to my practice in order to better comply with the standards of the profession.

**III. CONTINUOUS LEARNING ACTIVITY CREDIT PROGRAM**

The Continuous Learning Activity Credit Program section of the Self Assessment Tool provides a means to identify Learning Goals, which are relevant to a member's practice. The member is required to identify at least three Learning Goals. A rating of non compliance with a specific indicator is not necessarily a negative finding. It can be used positively to assist members in developing their knowledge and skills in the pursuit of practice excellence and incorporated into one of the member's Learning Goals. The Continuous Learning Activity Credit Program section can be used to identify Learning Goals, which will address areas of practice where improvement may be indicated, if excellence in practice is to be achieved and maintained.

The Continuous Learning Activity Credit Program section replaces CASLPO's Continuing Education Program. **Now all continuing education is to be self-directed.** All members must identify at least three Learning Goals and relate all of their learning activities to these Learning Goals.

This self directed learning program is based on the following assumptions:

1. CASLPO members have a long positive history of reporting continuing education equivalents, which is preserved in the current program.
2. Learning that is tailored to specific self-identified goals is more effective in changing clinical behaviour than opportunistic learning where no prior goals have been set.
3. Self-directed learning is at least as effective as, if not more effective than traditional didactic learning; thus members will not be penalized by maximum credit allowances in self-directed learning categories. This will permit the development of creative and clinically relevant learning opportunities.
4. Learning is enhanced when it is achieved through a variety of different activities.
5. The impact of learning on clinical skills should be evaluated.
6. An integrated Self Assessment Tool and Continuing Education Program will simplify compliance requirements, better quantify continuous learning and provide a more relevant clinical learning experience for members.

Members are required to identify at least three Learning Goals that both relate to their self-evaluation and have direct relevance to the member's professional practice. The continuous learning activities will be categorized according to the Learning Goals selected by the member. Members need to demonstrate how both the Learning Goals and the specific continuing education activities will enhance and support the quality of the services provided.

Members who do non-clinical related work and academic members are expected to fill out the Self Assessment Tool although most, if not all, of the compliance ratings will non applicable. These members will still be required to select Learning Goals and acquire 45 CLACs during the course of three years. In these cases the Learning Goals will relate to the member's major responsibilities in their positions.

## **PROCEDURES FOR REPORTING**

### **1. Identifying Learning Goals**

On completing the Self Assessment Tool, members must formulate at least three Learning Goals. These are placed on the forms in the Self Assessment Tool. These goals are meant to be broad statements of the member's purpose in participating in continuous learning. Where these goals are directly related to an indicator, that indicator must be specified. However, not all Learning Goals need to relate to an indicator. In addition, Learning Goals may be added during the course of the year, independent of Self Assessment Tool review. Learning goals may be formulated to capture continuous learning opportunities, which arise but were not planned and may not fit into the existing goals. The identification of Learning Goals is meant to be a flexible and ongoing process. Extra pages may be added to accommodate more Learning Goals however; members are required to have a minimum of three Learning Goals.

### **2. Identifying Learning Activities**

Each Learning Activity must be linked to a Learning Goal. In this way all Learning Activities are linked to a specific objective. There can be numerous Learning Activities, which relate to one Learning Goal. Learning Activities may be summarized on the CLAC Summary Form but should be specifically listed on the CLAC Detailed Learning Activity Log. These details should include as relevant dates, titles and authors of readings and presentations, websites searched and titles, dates and instructors of courses. Learning Goals can be formulated to address continuing education opportunities, which the member was unable to predict. Members are required to have at least three Learning Goals.

### **3. Recording Learning Activities**

When an activity is completed, the Continuous Learning Activity Credits (CLACs) are recorded in relation to the relevant Learning Goal in the appropriate row. Credits are allocated according to Activities and Criteria For CLACs in Appendix A of the Guide. It is important to remember that not all valid activities are learning activities. Activities such as improving record keeping or obtaining consent are valid and necessary activities but they do not qualify as learning activities. For learning activities to count as CLACs, they must meet the criteria in the CLAC manual and be activities where quantifiable learning has occurred. Members are required to collect 45 CLACs in each three-year Self Assessment cycle. Also ensure that the details are recorded on the CLAC Detailed Learning Activity Log.

### **4. Determining Progress in Meeting Goal**

Every year members must review their Self Assessment Tool. In doing so they must also review their progress in meeting their learning goals. In the appropriate column of the Continuous Learning Activity forms, members should briefly comment on any success or

difficulty they may have encountered in achieving their goals. Members may also provide some explanation for their rating of impact on practice as outlined below.

## 5. Determining Impact on Practice

In the course of reviewing their continuous learning goals, members are expected to rate how learning activities have affected their practice. The impact of learning on practice is rated for each Learning Goal according to the following scale:

- 0 No progress or impact
- 1 Moderate progress, little impact
- 2 Moderate progress, significant impact
- 3 Great progress, little or no impact
- 4 Great progress, significant impact

Members whose primary responsibility is administration will rate the impact of their learning activities on their administration skills. Academic members will rate the impact of their learning activities on their teaching, research or administrative duties.

## 6. Schedule of Reporting

Year 1 (2011)

1. Complete the 2011 Self Assessment Tool; member would rate compliance on indicators.
2. Member will select three Learning Goals for the coming year and link them to an indicator if appropriate. Not all Learning Goals need to be linked to indicators.
3. During the course of the year the member will track learning activities for each of the goals and record CLACs to represent these activities.
4. Member to submit a copy of the 2011 Self Assessment Tool only if randomly selected. (Member may be asked to submit 2008-2010 CLAC reporting forms if randomly selected for a *Peer Assessment*).

Year 2 (2012)

1. Member will review 2011 Self Assessment Tool.
2. Member will note progress in meeting learning goals from 2011 (possibly by describing in narrative form impact on practice or competence).
3. Member will rate the impact on practice.
4. Member will formulate new learning goals for 2012 or restate previous ones based on progress. There must be 3 current Learning Goals identified in each year of the program.
5. Member will continue to track learning activities for each of the goals and record CLACs to represent these activities in 2012.
6. Member to submit a copy of the 2011 Self Assessment Tool only if randomly selected.

Year 3 (2013)

1. Member will review Self Assessment Tool.
2. Member will note progress in meeting learning goal from 2012 (possibly by describing in narrative form impact on practice or competence).
3. Member will rate the impact on practice.
4. Member will formulate new learning goals for 2013 or restate previous ones based on progress. There must be 3 current Learning Goals identified in each year of the program.

5. Member will continue to track learning activities for each of the goals and record CLACs to represent these activities.
6. Member to submit a copy of the 2011 Self Assessment Tool only if randomly selected.

Year 4 (2014)

1. Complete 2011 – 2013 CLAC reporting forms. If member is selected to submit the Self Assessment Tool in 2010, a copy of the 2011 – 2013 Tool would be submitted.
2. The 2014 Self Assessment Tool will be completed. Member would rate compliance on indicators.
3. Member will select three Learning Goals for the coming year

## 7. Starting a Self Assessment Tool in mid cycle

The Self Assessment cycle is the same for all members. When members join the College mid cycle they are required to fill out a Self Assessment Tool and identify a minimum of three Learning Goals. They begin to collect CLACs and review their Learning Goals annually as well as rating the impact of continuing education on practice. Members who join mid-cycle will not be required to collect 45 CLACs at the end of the cycle but their Continuous Learning Activity forms must show evidence of three current Learning Goals, some learning activity and annual review as required.

### APPENDIX I

This optional checklist may be used by members when determining if all the required elements of a record are in place.

### APPENDIX II

This optional checklist may be used by members when determining if all the required elements of a financial record are in place.

### APPENDIX III

This optional checklist may be used by members when compiling and cataloguing evidence of compliance.

### FAX BACK

The Self Assessment Tool is not a static document. Although this version of the tool has been adopted by CASLPO for use by its members in its current form, it will be consistently revised and updated based on members' feedback. After using the Self Assessment Tool, members are encouraged to provide input by using the Fax Back form at the end of the tool. We want to hear from you.

## APPENDIX A



**College of Audiologists and  
Speech-Language Pathologists of Ontario**

# CLAC (Continuous Learning Activity Credit) MANUAL

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## **RATIONALE FOR THE CLAC PROGRAM**

Continuous Learning Activities (CLACs) are an integral part of the Self Assessment Tool. After having done an in depth self assessment of their compliance with the standards of the profession, CASLPO members have the opportunity to reflect on the changes that they would like to see in their approach to practice and reflect on ways to realize those changes. Hence the Continuous Learning Activity section of the Self Assessment Tool provides a means for the member to identify Learning Goals which will form the basis of a continuous professional development plan aimed at enhancing skills and developing techniques to improve on clinical practice. A rating of non compliance with a specific indicator can serve as an alerting mechanism. It can be used positively to assist members in developing their knowledge and skills in the pursuit of practice excellence. The Continuous Learning Activity section is a means to identify Learning Goals that will address areas of practice where improvement may be indicated if excellence in practice is to be achieved and maintained.

The Continuous Learning Activity section replaces CASLPO's Continuing Education Program. Now all continuing education is to be self-directed. All members must identify at least three Learning Goals and relate all of their learning activities to these Learning Goals. This is the basis of the CLAC program.

The rationale for the CLAC program is based on principles derived from the adult learning continuing professional development literature. This body of work maintains that accumulation of credit hours from course attendance is not the most effective means of clinical learning. It demonstrates that the effectiveness of ongoing professional development is enhanced when it is:

- Self directed
- Goal oriented
- Within the clinical environment
- Interactive
- Evaluated

**The CLAC Program is based on the following assumptions:**

1. Continuous professional learning is important to ensure members remain current in their practice.
2. CASLPO members have a long positive history of reporting continuing education equivalents, which is preserved in the current program.
3. Learning that is tailored to specific self-identified goals is more effective in changing clinical behaviour than opportunistic learning which, is not goal directed.
4. Self-directed learning is at least as effective as, if not more effective than traditional didactic learning; thus members will not be penalized by maximum credit allowances in self-directed learning categories. This will permit the development of creative and clinically relevant learning opportunities.
5. Learning is enhanced when it is achieved through a variety of different activities.
6. The impact of learning on clinical skills should be evaluated.
7. An integrated Self Assessment Tool and Continuing Education Program will simplify compliance requirements, better quantify continuous learning and provide a more relevant clinical learning experience for members.
8. CASLPO members are self motivated to maintain rigorous continuous professional learning.

## REQUIREMENTS OF THE CLAC PROGRAM

### General Requirements

The requirements of the CLAC program are:

1. Members must have at least 3 learning goals per year.
2. All learning goals must meet specified criteria.
3. All learning activity must be related to a learning goal.
4. All learning activities must fall in one of the following categories:
  - a. Courses Taken
  - b. Self Study
  - c. CASLPO Programs
  - d. Contributions to the Profession
5. All learning activities must meet the criteria for each of the categories.
6. Members are required to include a learning goal that relates to any indicator of the Self Assessment Tool that has been identified by the member as partially compliant or non compliant.

Since its inception, the Continuous Learning Activity section of the Self Assessment Tool has been intended as a way to address ratings of partial compliance and non compliance. Instead of viewing such ratings on a specific indicator as a negative finding, the CLAC program allows for this evaluation to be used positively by assisting members in identifying which areas require professional development in the pursuit of practice excellence.

7. Members must review their learning activities annually and record what progress was made in meeting the goal.
8. Members must rate the impact of their learning on their practice annually.
9. Members must accumulate 45 Continuous Learning Activities (CLACs) in a three-year period.
10. Members may not claim CLACs for activities that are part of a remediation order by the College (such as targeted peer assessment, registration orders outside the initial practice period or courses taken to fulfill an order of the College).
11. All members are required to ensure that they are meeting the requirements of the CLAC program. Only members who are randomly selected to submit their Self Assessment Tools will be required to report their CLACs to CASLPO.

## LEARNING GOALS

On completing the Self Assessment Tool, members must formulate at least three Learning Goals. These are placed on the Opportunity for Growth and Change forms in the Self Assessment Tool. These goals are meant to be broad statements of the member's purpose in participating in continuous learning. Where these goals are directly related to an indicator, that indicator must be specified, but the indicator alone is not sufficient to be a Learning Goal. It is also important to remember that not all Learning Goals need to relate to an indicator.

Learning Goals may be added at any time, independent of Self Assessment Tool review. Learning goals may be formulated to capture continuous learning opportunities that arise but were not planned and may not fit into the existing goals. The identification of Learning Goals is meant to be a flexible and ongoing process. Extra pages may be added to accommodate more Learning Goals, however, members are required to have a minimum of three Learning Goals.

### Criteria for Learning Goals

Learning Goals are a crucial part of the CLAC Program. Learning Goals define the scope and purpose of the learning that will take place. It is important that members give the formulation of Learning Goals serious consideration, as they will be evaluating their learning based on these goals. A member must have a minimum of three Learning Goals.

#### All learning goals must:

- 1. Define the information to be learned and incorporate the purpose of the learning.**
- 2. Include sufficient detail to determine if the learning objective was met.**
- 3. Relate to the member's clinical practice.**
- 4. Refer to a learning activity.**
- 5. Address any areas of partial or non-compliance on the Self Assessment Tool.**

#### 1. Define the information to be learned and incorporate the purpose of the learning.

A Learning Goal should articulate what the member wants to learn and why the member wants to learn it. It should clearly state the purpose of the learning activities the member is about to embark on.

Clear Example:

*“Acquire knowledge of supervision and evaluation methods in order to further develop skills to enhance role as clinical educator.”*

The objective of the learning is clearly defined. The member wants to know more about supervision and evaluation methods. The purpose of the learning is stated. The member wants to develop skills and enhance the clinical educator role. When evaluating whether the goal was met the member will know to look at whether the intended knowledge was in fact acquired and whether it had an impact on the clinical education provided.

Unclear Examples:

*“Take on a student.” “Mentor a new graduate.”*

It is not clear what information is going to be learned. While striving to provide clinical education and mentorship opportunities are laudable goals on their own, they are not Learning Goals unless the information to be learned is specified and the purpose is defined.

## **2. Include sufficient detail to determine if the learning objective was met.**

The goal may be general but it should include enough detail so that in looking back the member understands what it was the member intended to learn.

Clear Examples:

*“To learn about a range of assessment and treatment procedures to improve my approach to fluency treatment.”*

*“To learn about the acoustic parameters of a wider range of hearing aids to provide my patients/clients with more choice.”*

In both these clear examples the information to be learned is quite broad yet it is still defined sufficiently to allow the members to determine if the goals were met. In addition, the purpose for the learning is clearly stated to assist the members to stay focused when taking on such a broad learning objective.

Unclear Example:

*“To learn more about stuttering.”*

*“To learn more about hearing aids.”*

These unclear examples require further definition. If the member learned one piece of incidental information, the goals would have been theoretically met but the learning may likely have no relevance to clinical practice. There is nothing in the way the goal is stated to assist the member to determine if the learning is of clinical value.

## **3. Relate to the member’s clinical practice.**

The purpose of the Learning Goal is to identify strategies, which will improve the quality of the member’s practice. Goals must have a clear relationship to the clinical work of the member.

Clear Examples:

*“To learn techniques to deal with Autism, ADHD and other behaviours to improve my approach in therapy with patients/clients who exhibit these characteristics.”*

*“To learn techniques to assess hearing in frail elderly patients/clients to improve the reliability of my assessments for this population.”*

All Learning Goals should be clinically relevant and have a demonstrated relationship to the provision of clinical service delivery. These clear examples can be easily related to the members’ practices. While the CLAC program is a self-directed learning initiative, the direction is defined by the member’s clinical practice.

Unclear Example:

*“Learn about syndromes.” “Learn about hearing aids.”*

While learning for the sake of learning may be a commendable pursuit, it does not belong in a professional learning program. The Learning Goal must clearly state how the learning will assist the member in providing quality care to patients/clients. These examples do not do that.

#### **4. Refer to a learning activity.**

All goals must define learning activities.

Clear Examples:

*“To learn more about office administrative procedures and clinic management to be incorporated into set up of new office to ensure the provision of quality care.”*

*“To learn about time management strategies to ensure effective and efficient caseload management.”*

**The information to be learned and the clinical purpose for the learning are clearly stated. These examples illustrate how learning activities, which in the past would have been considered not directly related to clinical activities, can in fact have direct relevance.**

Unclear Examples:

*“Set up new office.” “Increase billings and improve profit margins.”*

These examples define specific activities, which may have significant positive impact on the member’s practice but they are not learning activities and cannot be accepted as a Learning Goals. In addition the clinical relevance of these activities is not clear.

## 5. Address any areas of partial or non-compliance on the Self Assessment Tool.

Learning Goals should be derived from the member's Self Assessment Tool. All areas that have been identified as partially compliant or non-compliant must be reflected in the Learning Goals.

Clear Example:

*“Learn about requirements for obtaining and documenting consent and methods to increase efficiency and compliance.”*

The purpose of the Self Assessment Tool is to provide a structure for members to identify areas in which further learning will enhance the quality of clinical service. The formulation of Learning Goals is an important component of this process. On peer assessment, members who are found to be partially or non-compliant will be required to report Learning Goals which address these areas.

Unclear Example:

*“Increase documentation of consent.”*

A Learning Goal that is derived to assist a member in increasing compliance must still meet the previous stated criteria of Learning Goals. The information to be learned needs to be identified and the relevance to clinical practice should be acknowledged. In this unclear example, the learning activity is not identified.

## Using a Template to Ensure Learning Goals Meet Criteria

To further assist members in ensuring that their Learning Goals meet the criteria, CASLPO has developed a Learning Goal template which provides members with an option for formulating learning goals. Use of the template is not required but it may support members as they try to make sure that all the criteria for Learning Goals are met.

<b>The standard wording to refer to the learning activity would be one of the following:</b>	<b>The standard wording to state the purpose of learning would be one of the following:</b>
To learn more about..... <i>the information to be learned would then be defined.</i>	In order to..... <i>a statement relating the learning to the practice would then be added.</i>
To acquire knowledge of..... <i>the information to be learned would then be defined.</i>	To provide..... <i>a statement relating the learning to the practice would then be added.</i>
To further knowledge of..... <i>the information to be learned would then be defined.</i>	To ensure..... <i>a statement relating the learning to the practice would then be added.</i>

The following chart shows examples of how the template can be applied:

SUBMITTED LEARNING GOAL	GOAL USING TEMPLATE
Develop consultation skills to ensure client perspective is reflected.	To acquire knowledge about communication techniques in order to develop consultation skills to provide care where client perspective is reflected.
To maintain client confidentiality	To learn more about techniques to assist in maintaining client confidentiality in order to ensure that the sensitive nature of personal health information is respected.
As part of improved record keeping, will update report format to include data from new assessments.	To further knowledge of record keeping methods in order to update report format so that new assessment information can be included.
To explore community education opportunities regarding infant health and development	To acquire knowledge about infant health and development education resources in the community to better understand the needs of children and families on my caseload.
To increase exposure to professional discussion related to all areas of practice, increase communication with other SLPs for case discussion and brainstorming.	To learn more about how colleagues utilize clinical knowledge in problem solving specific cases to be able to improve goal setting in therapy.
To read articles to increase professional knowledge	To further knowledge of childhood language disorders to ensure that current techniques are used in my practice.

If members decide to use this template, it may be helpful in determining whether the requirements for learning goals are met. This is illustrated in the chart below:

<b>Refer to a learning activity</b>	<b>Define the information to be learned</b>	<b>State the purpose</b>	<b>Relate to practice</b>
To learn more about	<i>Communication Techniques</i>	In order to	<i>Develop consultation skills</i>
To acquire knowledge of	<i>Childhood language disorders</i>	To provide	<i>Current techniques in therapy</i>
To further knowledge of	<i>Clinical problem solving</i>	To ensure	<i>Better clinical problem solving</i>

## LEARNING ACTIVITIES

Learning activities go hand in hand with Learning Goals in fulfilling the essential requirements of the CLAC Program. Just as Learning Goals define the learning, the learning activities provide the means to meet the goals.

While there is a considerable amount of flexibility in choosing acceptable learning activities, criteria for learning activities must apply if the learning activity will be counted as a CLAC. Learning activities must fall into one of the following headings:

1. Courses Taken or Given
2. Self-Study
3. Clinical Guidance Activities
4. Contributions to the Profession
5. Practice Management

### Criteria for Continuous Learning Activity Credits (CLACs)

CLACs are calculated as 1 CLAC per hour of leaning activity. Certain activities have maximum amounts of CLACs which may be claimed as specified below:

#### 1. Courses Taken or Given

Any type of workshops, distance educational initiatives (such as web based), lecture, university course, in service education.

**No maximum**

#### 2. Self Study

Any type of goal directed self study which involves new learning such as readings, material review, preparation time for presentations for new learning only and manufacturer technological updates. These learning activities must:

1. be related to the learning goal

2. be specified in a detailed of list of materials read or reviewed on CLAC Detailed Learning Activity Log form.

**No maximum**

### **3. Clinical Guidance Activities (Including student supervision and consulting)**

This includes the following types of learning activities:

1. Study group
2. Providing mentorship
  - a. IPRs
  - b. practicing members
  - c. Supervision of AUD/SLP Students only
3. Being mentored

**Maximum of 15 CLACs per clinical guidance activity**  
**No maximum of separate clinical guidance activities**

### **4. Contributions to the Profession**

Any type of committee work for CASLPO or professional association committee activity.

**Maximum of 10 CLACs per year**

### **5. Practice Management**

This includes the following types of learning activities:

1. Self Assessment Tool (max is 5 CLACs/1<sup>st</sup> yr and 1 CLAC /annual review)

**Maximum of 5 CLACs in the 1<sup>st</sup> year of the Self Assessment Tool**  
**Maximum of 1 CLAC per year for annual review**

2. Peer Assessment (includes being assessed as part of the CASLPO random selection or conducting a CASLPO sponsored assessment).

**Maximum of 5 CLACs per Assessment**  
**Maximum of 10 CLACs per year**

Note:

Members may not claim CLACs for activities which are part of a remediation order by the College (such as targeted peer assessments, registration orders outside of the initial practice period or courses taken to fulfill an order of the College).

### **Which Learning Activities Count as CLACs and Which Don't**

This self-directed approach to learning activities provides members with greater flexibility in choosing appropriate learning activities to meet their stated Learning Goals. It allows for greater individualization in learning plans with the intention of making the learning more meaningful for members and increasing the impact on quality clinical service delivery. However, members are cautioned not to interpret greater flexibility as freedom to count any activity as a CLAC. As outlined above, the learning activities still must meet the specified criteria. Examples of activities which have been reported but cannot count as CLACs include:

- Setting up an office
- Writing advertisements for private practice
- Sending letters to potential referral sources and patient/clients
- Using volunteers to help with record management and filing
- Using specific equipment or therapy and testing procedures
- Increasing compliance with documentation requirements
- Administrative staff meetings that do not involve an education component
- Horseback riding
- Yoga courses for personal relaxation

These activities may be commendable, valuable and important but they are not learning activities. A true learning activity needs to allow for learning to occur and cannot be something that one simply does.

Continuous Learning Activity Credits may be counted only up to the maximum allowed as published in the in Appendix A of the Self Assessment Guide: Criteria for Continuous Learning Activity Credits.

While the CLAC program provides a great deal of flexibility in determining learning activities and having those activities count for credit, there are some limits on the number of CLACs which can be assigned to some learning activities. For example:

- A maximum of 5 CLACs for undergoing a peer assessment
- A maximum of 15 CLACs per clinical guidance activity.

Members should consult the Criteria for Continuous Learning Activity Credits to ensure that their CLACs do not exceed the published maximums.

Learning activities that are part of a remediation order by the College (such as targeted peer assessments, registration orders outside of the initial practice period or courses taken to fulfill an order of the College) do not count for CLACs.

### **PROGRESS and IMPACT on PRACTICE RATING**

Every year members must review their Self Assessment Tool. In doing so they must also review their progress in meeting their Learning Goals and the impact of the learning on clinical practice. In the course of reviewing their Learning Goals, members are expected to rate how learning activities have affected their practice. The progress and impact of learning on practice is rated for each Learning Goal according to the following scale:

- 0 No progress or impact
- 1 Moderate progress, little impact
- 2 Moderate progress, significant impact
- 3 Great progress, little or no impact
- 4 Great progress, significant impact

Members whose primary responsibility is administration will rate the progress and impact of their learning activities on their administration skills. Academic members will rate the progress and impact of their learning activities on their teaching, research or administrative duties.

The purpose of this rating is to have members consider the progress made in meeting the learning goals and how the learning has affected practice and had an impact on the quality of the care that is provided. Members should always make this rating in relation to their clinical service delivery. There is no requirement that the progress and impact rating be at any specific level; there is no right answer. The College understands that it may be difficult for members to anticipate progress and the impact of their learning on clinical care so it may be that some ratings will be low. The College will expect, however, that in the year subsequent to a low progress and impact rating, the member will revise the Learning Goal or learning activity in an attempt to better meet the learning goals and increase the impact of the continuing education on clinical care. The basic premise of the self directed learning program is that it will have a positive impact on the quality of care provided by the member.

Evaluating the effectiveness of learning in this way can help a member determine if a goal is resolved or if it was unsuccessful or poorly formulated, in which case the goal will not be carried over to the next year. It can also help determine if the learning is in fact having any effect on clinical care. If not, both the goals and learning activities would need to be evaluated..

## REPORTING REQUIREMENTS

### Year 1 (2011)

1. Complete the 2011 Self Assessment Tool; member would rate compliance on indicators.
2. Member will select three Learning Goals for the coming year and link them to an indicator if appropriate. Not all Learning Goals need to be linked to indicators.
3. During the course of the year the member will track learning activities for each of the goals and record CLACs to represent these activities.
4. Member to submit a copy of the 2011 Self Assessment Tool only if randomly selected. (Member will be asked to submit 2008-2010 CLAC reporting forms if randomly selected for a *Peer Assessment*).

### Year 2 (2012)

1. Member will review 2011 Self Assessment Tool.
2. Member will note progress in meeting learning goals from 2011 (possibly by describing in narrative form impact on practice or competence).
3. Member will rate the impact on practice.
4. Member will formulate new learning goals for 2012 or restate previous ones based on progress. There must be 3 current Learning Goals identified in each year of the program.
5. Member will continue to track learning activities for each of the goals and record CLACs to represent these activities in 2012.
6. Member to submit a copy of the 2011 Self Assessment Tool only if randomly selected.

Year 3 (2013)

1. Member will review Self Assessment Tool.
2. Member will note progress in meeting learning goal from 2012 (possibly by describing in narrative form impact on practice or competence).
3. Member will rate the impact on practice.
4. Member will formulate new learning goals for 2013 or restate previous ones based on progress. There must be 3 current Learning Goals identified in each year of the program.
5. Member will continue to track learning activities for each of the goals and record CLACs to represent these activities.
6. Member to submit a copy of the 2011 Self Assessment Tool only if randomly selected.

Year 4 (2014)

1. Complete 2011 – 2013 CLAC reporting forms. If member is selected to submit the Self Assessment Tool in 2010, a copy of the 2011 – 2013 Tool would be submitted.
2. The 2014 Self Assessment Tool will be completed. Member would rate compliance on indicators.
3. Member will select three Learning Goals for the coming year

## 2. Starting a Self Assessment Tool in mid cycle

The Self Assessment cycle is the same for all members. When members join the College mid cycle they are required to fill out a Self Assessment Tool and identify a minimum of three Learning Goals. They begin to collect CLACs and review their Learning Goals annually as well as rating the impact of continuing education on practice. Members who join mid-cycle will not be required to collect 45 CLACs at the end of the cycle but their Continuous Learning Activity forms must show evidence of three current Learning Goals, some learning activity and annual review as required.

## 3. Forms

Some members have reported that the CLAC forms are not adaptable. There may not be enough room to record all of the learning activities. If learning goals are to be changed or rearranged the form does not allow this to be done easily. The form is available in Word format on the CASLPO website [www.caslpo.com](http://www.caslpo.com) under Self Assessment in the Member Information section. Some members have downloaded this form onto their personal computers and saved a digital version. This allows them the flexibility to incorporate as many learning activities as they want for any one learning goal. They also have the opportunity to review and revise learning goals as their learning program requires. All members can take advantage of this and tailor the form to allow them to get the most out of the CLAC program.

## HOW CLACS ARE EVALUATED

### Evaluation of CLACs on Self Assessment

When CASLPO determined that a self-directed learning program with a credit based system would be best suited to meet the needs of the College and its members, it was decided that members would be the best judge of whether their learning plans met their individual needs. As a result, the members' submitted Continuous Learning Activity Credit plans are evaluated solely for completeness.

When members are randomly selected to submit their Self Assessment Tools their submissions are evaluated on the following administrative parameters:

1. Members will be required to have at least 3 learning goals per year.
2. All learning activity must be related to a learning goal to be counted as a CLAC.
3. Members must make a statement of progress in meeting the goal.
4. Members must rate the impact of their learning on their practice.
5. Members must collect 45 Continuous Learning Activities (CLACs) in a three-year period.

Members who do not meet these criteria are notified and required to resubmit their CLACs. Members do not receive feedback on whether their Learning Goals meet criteria. Members only receive feedback on the number of CLACs they have collected at the end of the cycle and only then, if they have not met the minimum criteria of 45 CLACs.

### Evaluation of CLACs on Peer Assessment

More formal evaluation of a member's learning plan occurs on peer assessment. Members are encouraged to use the peer assessor as a resource to assist in finding creative and meaningful learning activities which would have a maximum impact on practice. Within this context, members receive feedback from the peer assessor and the Quality Assurance Committee on their learning goals and CLACs.

During a peer assessment CLACs are evaluated based on a model which:

1. Preserves the self directed approach to continuous professional learning.
2. Provides members with the feedback they are requesting.
3. Provides clear guidance on College expectations for continuous learning.
4. Ensures that the self-assessment process is used to full benefit when determining a learning plan.

Peer assessors will work with members to ensure that their CLACs meet the criteria as listed above. Members who are peer assessed will have the opportunity to update their CLAC reporting during the peer assessment. The peer assessor will include a report on the member's

CLACs which will be forwarded to the QA Committee. Members always receive the peer assessment report before it is presented to the QA Committee so that they may provide comments to be considered at the same time. This will continue. Members will now also be given the chance to update and comment on their CLAC submission before it is reviewed by the QA Committee.

The purpose of this approach is to:

1. Further refine and clarify the requirements of the CLAC program.
2. Maintain the philosophy of self directed learning.
3. Build in an accountability component to the CLAC program.
4. Ensure that the Self Assessment Tool evaluation and continuing professional education have a formative relationship.
5. Enhance member understanding of the goals and expectations of the CLAC program.
6. Provide feedback to members as part as an overall assessment of compliance with the standards of the profession.

## **HISTORY OF CASLPO'S CONTINUING PROFESSIONAL EDUCATION PROGRAMS**

In 1999, CASLPO introduced the notion of continuing competence with the following statement of purpose:

“Within the philosophy of Continuous Quality Improvement CASLPO believes that continuing education and professional activities enhance levels of knowledge, skill, and judgement necessary in the provision of client-focused care. The overall purpose of the Continuing Education and Professional Activities Program is to promote continued competence among the members of the College.”

This purpose encapsulated the primary values of the Continuing Education Equivalent Program, which was then introduced and served the College and its members well until 2005.

With the publication of the 2005 Self Assessment Tool, CASLPO introduced a new way for members to demonstrate and report their on-going professional education. In the past members reported their Continuing Education Equivalents (CEEs) to the College at the end of every 3-year cycle. In the new program, members are required to accumulate Continuous Learning Activity Credits (CLACs) and document them on the Continuous Learning Activity section of the Self Assessment Tool. Members are no longer required to report CLACs routinely at the end of a cycle, but must submit their CLACs if they are randomly chosen to submit their Self Assessment Tool

The current CLAC program was born out of a reconsideration of the entire Quality Assurance program. Since the CEE program had been initiated, both the Self Assessment Tool and the Peer Assessment process had been developed. The Self Assessment Tool included a section for Continuous Learning Activity, which allowed members to identify aspects of professional

practice that might be improved and to propose learning activities to foster that improvement. This was our members' first experience with self-directed learning and it proved to be a great success. The next logical step was to incorporate the continuing education program into the Self Assessment Tool. This was achieved in 2005.

In the current CLAC program all learning must be tied to a Learning Goal and there is no longer a maximum in the amount of self-study that can be counted. Every year members must total their CLACs, summarize progress in meeting the goal and rate the impact of the learning on practice. Members no longer routinely report their CLACs to the College but are required to submit their CLACs if they are one of the 250 randomly selected members to submit their Self Assessment Tool.

Over the years, CASLPO's Continuous Learning Activity Program has matured and been refined. In the course of the move to a more self directed learning program, CASLPO has entrusted its members with more autonomy for their continuing professional education.

CASLPO members have distinguished themselves by showing their commitment to life long learning. Audiologists and speech-language pathologists have embraced the new program with their questions, their compliance and their constructive suggestions. CASLPO has responded by incorporating many of the suggestions into the refinement of the program.

## **EVALUATION OF THE CLAC PROGRAM TO DATE**

Analysis of the submitted CLACs submitted by members has revealed a number of interesting trends.

1. Members take their professional education very seriously.

CASLPO members continue to distinguish themselves as dedicated professionals who believe that professional continuing education is an important part of their clinical responsibility to their patients/clients. Members want to learn in a way that enhances their practice performance. Members are overwhelmingly compliant with the CLAC program as they were with previous continuing education programs.

2. Members are committed to the CLAC program.

CASLPO members have managed the change to a new continuing education program with ease. The fact that the change has generated many questions from members and requests for guidance shows that members want to incorporate this new approach to continuous learning into their continuing learning plans and they want to do it correctly. Members want to make the most out of the CLAC program.

3. Members have embraced the concepts of self-directed learning.

CASLPO members appreciate that they are now entrusted with the responsibility to ensure that their continuous learning is an integral part of all that they do as professionals. The CLAC program does not require mandatory reporting on a regular basis. Freedom from this requirement allows members to concentrate on the quality of their continuing education and to ensure that the learning goals and learning activities meet their individual needs.

4. Members want to be creative when choosing learning activities that best meet their professional needs.

CASLPO members have chosen many original learning activities which meet the criteria for CLACs and allow for different learning styles and needs. Members are learning in ways that have the greatest potential to assist them in meeting their learning goals. Members have also requested support in evaluating which learning activities meet the criteria for the CLAC program and how to capture them in the format of the Self Assessment Tool.

5. Members want feedback on their CLACs.

With the fundamental changes that have occurred in the required continuing education for audiologists and speech-language pathologists, members are sometimes at a loss as to whether or not they are on the right track. Our analysis of the 500 submissions shows that CASLPO members have for the most part understood the requirements of the CLAC program and are highly compliant. Yet it would appear that based on the questions received by the College, such aggregate feedback is not sufficient to meet our members' needs. Members are asking for more.

6. Members use a variety of sources when determining their education plans.

CASLPO members have derived their learning goals in many innovative ways. Some have looked at their practices, others have looked at their work environments, still others have used their employer performance evaluations and many have used all these and more. Many members tell us that the Self Assessment Tool is helpful in determining learning goals but an equal number tell us that they are unsure of how one's evaluation on the Self Assessment Tool can assist in the formulation of learning goals.

As CASLPO and its membership became more familiar with this self directed learning program, it was apparent that the peer assessment process presented a perfect opportunity for a member and a professional peer to discuss all aspects of the CLAC program. Peer assessors reported that members appreciated the chance to further refine their learning plans and that members were devising some innovative and effective learning strategies. Members requested feedback on their compliance with the program. The program is unfamiliar and members have reported feeling unsure whether they are maximizing their learning within this new structure. Members wanted to know how they were doing.

This led the Quality Assurance Committee to decide that during the 2007 Peer Assessment Cycle, peer assessors and the Quality Assurance Committee would give members feedback on their learning goals and their CLACs. Peer assessors will review all aspects of the CLAC program with the member. They will look at the member's completed forms for 2005 and 2006 as well as their learning goals for 2007. The peer assessors will assist the member in determining whether their learning goals meet the criteria for a learning goal. They will then ensure that all the reported CLACs meet the criteria as set out on page 21 of the Self Assessment Guide. The peer assessor and the member together will look at the member's progress statement and how the member rated the impact of the learning on his/her practice. This discussion will allow the member to take advantage of the peer assessor's knowledge and experience and find out what other members are doing in order to enhance their continuing education experience with new ideas. This will provide member with the chance to consider other approaches to continuing professional education. This discussion will also allow the peer assessor to learn from the member. Peer assessors report that the members that they come to know through a peer assessment are a great resource of inventive and novel ideas. Thus this information can be shared with other members. And so the cycle continues and the CLAC program continues to develop.

Continuing professional education is a cornerstone of professional self-regulation. CASLPO members have demonstrated their dedication and commitment to continuous learning. With over 500 Self Assessment Tool submissions since the new Continuous Learning Activity Credit program was introduced in 2005, it is apparent that members have taken their responsibility to keep up to date and constantly learning seriously. As members increase their understanding of the CLAC program and as the program becomes further refined, CASLPO can continue to demonstrate that our members are competent and current in the fields of Audiology and Speech-Language Pathology.

## **FREQUENTLY ASKED QUESTIONS**

Do I need to submit my CLACs to CASLPO at the end of each year?

No. CASLPO abolished the annual reporting requirement of continuous professional learning in 2004. CASLPO members were overwhelmingly compliant and demonstrated the personal accountability required to make a self directed learning program successful. As a result, annual reporting of CLACs is not required; however, members are required to record their CLACs on an annual basis as well as comment on progress in meeting learning goals and rate the impact of the learning on practice. This must be done on an annual basis.

Do I need to submit my CLACs to CASLPO at the end of the three year cycle?

Each year 250 members are randomly selected to submit their Self Assessment Tools. As CLACs are reported on the Continuous Learning Activity section of the Self Assessment

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Tool this is required as part of that submission. CLACs are reviewed to ensure that they are complete and meet the requirements of the program. Individual learning plans are not evaluated for the quality and type of learning; this is a self directed learning program after all. Even if members are not selected to submit the Self Assessment Tool, they still must complete the CLAC form each year.

Do I need to accumulate 45 CLACs in a three year cycle if I have not been practicing for part of that time?

All CASLPO members registered in the General and Academic categories must accumulate 45 CLACs in each three year cycle. If you are registered in the Non Practicing category, you do not have to accumulate CLACs while you are non practicing but if you wish to return to practice, you will have to demonstrate at a minimum that you have three learning goals for the year that you intend to return to practice. Even if you are non practicing for part of a cycle, you still need to accumulate 45 CLACs by the end of the cycle.

How can I accumulate CLACs if I don't have the opportunity to go to courses?

The CLAC program is a self directed learning program. As a result, there are only minor limits on the amount of self study that can be done. If a member acquires CLACs for being mentored by another more experienced mentor, a maximum of 15 CLACs can be counted. If a member credits CLACs for preparation time for a poster, presentation or course, a maximum of 5 CLACs can be counted. Other than that, there are no restrictions on self study. Members may read materials, review video or audio tapes, or participate in a study group and none of these activities need be limited. Documentation of the self study must be maintained.

Which CLAC cycle am I in?

In 2005, CASLPO abolished different continuing education cycles for members. Now all members are in the same cycle. The current cycle runs from 2008 to 2010. That means that all members must accumulate 45 CLACs by the end of 2010 provided they have been registered for the entire three years of the cycle.

## SUMMARY

1. Members must have at least 3 learning goals per year.
2. All learning goals must meet the following specified criteria:
  - a. Define the information to be learned and incorporate the purpose of the learning.
  - b. Include sufficient detail to determine if the learning objective was met.
  - c. Relate to the member's clinical practice.
  - d. Refer to a learning activity.
  - e. Address any areas of partial or non-compliance on the Self Assessment Tool.
3. All learning activity must be related to a learning goal.
4. All learning activities must fall in one of the following categories:
  - a. Courses Taken
  - b. Self Study
  - c. CASLPO Programs
  - d. Contributions to the Profession
5. All learning activities must meet the criteria for each of the categories.
6. Members are required to include a learning goal that relates to any indicator of the Self Assessment Tool that has been identified by the member as partially compliant or non compliant.
7. Members must review their learning activities annually and record what progress was made in meeting the goal.
8. Members must rate the impact of their learning on their practice annually.
9. Members must accumulate 45 Continuous Learning Activities (CLACs) in a three-year period.
10. Members may not claim CLACs for activities which are part of a remediation order by the College (such as targeted peer assessment, registration orders outside the initial practice period or courses taken to fulfill an order of the College).
11. All members are required to ensure that they are meeting the requirements of the CLAC program. Only members who are randomly selected to submit their Self Assessment Tools will be required to report their CLACs to CASLPO.