

SPEECH THERAPY ASSISTANT COMPETENCY PROFILE

Name:	Date of hire:
Title:	Employee number:
License number:	Evaluation date:
License renewal date:	Specialty certification (if applicable): Expiration date:
BLS renewal date:	
Other:	

Key for met/not met categories and self-needs assessment:

1. Able to perform independently
2. Able to perform after review of information
3. Able to perform with assistance only
4. Unable to perform

Time frame:

3 months = 3m
 6 months = 6m
 1 year = 1 yr

* = Annual evaluation required

Task/Behavior	References: A. Review policy/procedure B. Direct observation C. Video review D. Competency testing lab E. Written test F. Self-study packet	A	B	C	D	E	F	Date	Instructor Initials	Time Frame	Met	Not met	Self-needs Assessment
A. DEPARTMENT OVERVIEW													
Tour of (<i>PACE program</i>)	Guided tour									3m			
Dress code	Policy #									3m			
Clock in/out, sign in/out	Policy #									3m			
Telephone & intercom system	Policy #									3m			
Location of manuals	Guided tour									3m			
Staff in-services	Guided tour									3m			
B. DEPARTMENT SAFETY PROCEDURES													
Fire safety procedure*	Disaster manual, P&P									3m			
Disaster plan, evacuation plan*	Disaster manual, P&P									3m			
Location of safety manuals*	Guided tour									3m			
Hazardous materials	Hazardous materials manual									3m			
Body mechanics	PT program									3m			
Use of restraints*	Policy #, restraint P&P									3m			
CPR, basic life support (every 2 years)	Policy #									6m			
C. INFECTION CONTROL													
Handwashing	Infection control manual									3m			
Standard precautions*	Infection control manual									3m			
TB control, fit check	Policy #									3m			
Immunizations ♦ PPD yearly (mandatory)* ♦ Flu vaccination (counseling)	Policy #, unit learning resources									3m			
D. RESOURCE MANAGEMENT													
Tour of supply room(s)	Guided tour									3m			
Ordering of supplies	P&P manual									3m			
E. ASSESSMENT OF PARTICIPANTS													
Intake and enrollment policies	P&P manual									3m			
Language (expressive/receptive)	P&P manual									3m			
Articulation	P&P manual									3m			
Auditory processing	P&P manual									3m			
Voice	P&P manual									3m			
Fluency	P&P manual									3m			
Aural habilitation	P&P manual									3m			
Dysphagia, oral-motor	P&P manual									3m			
Augmentative, alternative communication	P&P manual									3m			
Appropriateness of current assistive, adaptive devices	P&P manual									3m			

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		B						
C								
D								
E								
F								
F. USE AND MAINTENANCE OF EQUIPMENT								
Augmentative, alternative communication devices ♦ Communication notebooks ♦ Communication boards	Speech manual				3m			
Oral motor facilitation tools ♦ Laryngeal mirror	Speech manual				3m			
Audiometer	Speech manual				3m			
Assistive listening devices, hearing aids	Speech manual				3m			
G. CARE OF PARTICIPANTS								
Articulation treatment	Speech manual				3m			
Language treatment	Speech manual				3m			
Auditory processing, cognitive treatment	Speech manual				3m			
Dysphagia/oral-motor treatment	Speech manual				3m			
Fluency treatment	Speech manual				3m			
Voice treatment	Speech manual				3m			
H. PARTICIPANT SPECIFIC								
Age specific*	Module				3m			
Latex allergy*	Module				3m			
Limitation of participant movement	P&P manual				3m			
Cultural respect*	Module				3m			
I. MANAGEMENT OF INFORMATION								
Unit therapy documentation	Medical records manual				3m			
Teaching documents	Medical records manual				3m			
Participant confidentiality	P&P manual				3m			
Completion of physician orders	Medical records manual				3m			
J. UNIT SPECIFIC								
Therapy attendance policy	Speech manual				3m			
Referral process	Speech manual				3m			
♦ Audiological evaluation	Speech manual				3m			
♦ Videofluoroscopy	Speech manual				3m			
K. QUALITY IMPROVEMENT								
Chart review	QI manual				3m			
QI committee	Meeting minutes				3m			

Date competency profile completed: _____

Action plan initiated: Yes No

(If yes, please add action plan to competency profile.)

I understand that it is my responsibility to notify my immediate supervisor if at any time I am unable to perform the basic competencies required to practice in my assigned clinical area.

Employee signature: _____

Preceptor signature: _____

(Attach the competency profile action plan here.)