|  |
| --- |
| De Montfort University, Faculty of Health and Life Sciences, Speech & Language Therapy N |
| DMU NEW RGB master_#76A6ABCase Presentation HandbookLevel 2 SLT studentsClinical Decision making and Intervention planning2017 to 2018 |

Contents

[Clinical decision making 5](#_Toc466541335)

[Collecting and assembling client data 5](#_Toc466541336)

[Creating an Individual Profile (IP) 6](#_Toc466541337)

[Formulating Hypotheses 8](#_Toc466541338)

[Planning intervention 8](#_Toc466541339)

[Theory to practice – what does this mean? 9](#_Toc466541340)

[Evidence Based Practice 15](#_Toc466541341)

[Useful reading 16](#_Toc466541342)

[university assessment Writing the Case Presentation- assignment SALT2022 17](#_Toc466541343)

[Students who are working with clients in a group 18](#_Toc466541344)

[Students working as peers 18](#_Toc466541345)

[Students undertaking initial assessments 18](#_Toc466541346)

[Students working at a universal level or with non-referred clients. 18](#_Toc466541347)

[CONFIDENTIALITY 20](#_Toc466541348)

[SUMMARY OF THE STEPS TO FOLLOW 25](#_Toc466541366)

[STEPS 26](#_Toc466541367)

[STEP 1 26](#_Toc466541368)

[1.1 Relevant reported data 26](#_Toc466541369)

[1.2 Assessment data and analysis 27](#_Toc466541370)

[1.3 Speech, Language and communication samples 28](#_Toc466541371)

[Speech sample 28](#_Toc466541372)

[Language sample with summary of findings 30](#_Toc466541373)

[CASE EXAMPLES reported information/assessment 31](#_Toc466541374)

[Step 2: Create and present an individual profile (IP) 38](#_Toc466541375)

[Case example individual profile 40](#_Toc466541376)

[Step 3: Clinical description/diagnosis of client’s speech, language and communication difficulties 43](#_Toc466541377)

[Information about generating clinical hypotheses. 43](#_Toc466541378)

[Case example of hypotheses 44](#_Toc466541379)

[Step 4 47](#_Toc466541380)

[Summary and conclusions 47](#_Toc466541381)

[Case example summary and conclusions 48](#_Toc466541382)

[Step 5 References 50](#_Toc466541383)

[Step 6 University Assessment 51](#_Toc466541384)

[Case presentation/Viva preparation 51](#_Toc466541385)

[What kind of assessment is suitable? 52](#_Toc466541386)

[The viva protocol 54](#_Toc466541387)

[TEMPLATES 57](#_Toc466541388)

## Introduction

This handbook provides information and aims to guide students through a process designed to help develop clinical reasoning skills. These are essential skills which involve students drawing on the knowledge that they have been taught at university, and applying this to the information that they learn about their clients, in order to make clinical decisions about how speech and language therapy can provide a positive benefit.

This handbook also gives guidance about how to prepare for the university assessment case presentation for the Clinical Placement Module: SALT 2022. Students are required to present data from a client that they have worked with on placement

* This case study does not require students to make a video recording in placement
* You will also refer to these steps when looking at cases in SALT 2002.

Word limits. The word limit for the case presentation is 3,000 words. The word limit only refers to steps 2 to 4 inclusive. This does not include the case history data, reference list, or viva preparation. However students should keep information in Step 1 relevant and precise.

(Please note that due to the variety in the type of cases presented across the year group and the point in the care pathway of the clients in question, students will vary in the amount of information that they have to present.)

## clinical decision making

This section gives general information and guidance on the process of making clinical decisions and of the terminology involved. Please read this section before setting out on the preparation of your case study.

Clinical decision making*(can also be called “clinical reasoning” or as ‘making clinical judgments’)*

Clinical decision making is the overall name given to the process of making a series of informed judgments about the actions necessary for the management of a client. In order to make informed clinical decisions you must learn to collect, analyse and interpret client data and use this information to deduce explanations, and draw conclusions about your client’s communication difficulties, and the steps necessary to consider intervention, if required.

Part of the process involves picking up and following ‘clues’ that you have about your client. Some of these ‘clues’ are first revealed in the referral information and then continue to gradually emerge as you get to know your client better. Each ‘clue’ will enable you to develop key ‘hypotheses’ about the client’s speech, language and communication needs. As students your practice educators and university tutors will help you to identify the information that is needed and which aspects to prioritise.

Clinical decision-making also requires you to draw on and then integrate your developing theoretical knowledge with the knowledge you have about your client. Think back to modules (e.g. SALT 1209, SALT 2207, etc.) that you have studied or are studying and revisit learning from the relevant topics.

## Collecting and assembling client data

The first step in the process is to ensure that you are working with the most comprehensive information possible about the history, cause, nature, severity, and impact of the difficulties in the context of your client’s life.

Information collected about a client comes from three main areas;

* Collected/reported information. This may be taken directly from the client, carers, parents, teachers, doctors etc.
* Assessment data- this is the information that is collected by your SLT assessments, formal, informal, observation but may also include assessment data from other sources, such as audiology etc.
* Client preferences; what is important about this process from the client perspective and what the client wants to gain from the service.

Please note that assessment does not just take place only at the beginning of a client’s care pathway, but is continuous, as every session contributes to an understanding of a client’s difficulties and progress. Clinicians may also start intervention based on initial data and adjust this in later sessions which act as ‘diagnostic therapy’ that is, both helping a client to learn a new skill, and simultaneously gaining information about how the client learns and what might help for the future.

Essential background reading for collecting client data is;

* Chapter 3. Assessment: process and practice in Bray, M., A. Ross and Todd, C (1999) Speech and Language: Clinical Process and Practice. London. Whurr. Read pages 38 - 47 the section on ‘Information gathering’.
* Tomblin B, Morris, H & Spriestersbach, D.C (2000) Diagnosis in speech and language pathology. 2nd edition. San Diego. Singular Publishing Ch.3

## Creating an Individual Profile (IP)

Following comprehensive data collection you are required to construct an IP (Bunning, 2004) for your client. This section will enable you to organize and prioritise the most important aspects of the client data. You will need to select the pertinent information from the client data. The IP will give you a holistic overview of their needs and intervention is constructed on the basis of an analysis of a client’s strengths and weaknesses. It will help you to decide which aspects of a difficulty should be a priority for intervention and enable you to identify the strengths within the client and their situation which can be used to advantage in intervention.

The profile is made up of information which relates to a client’s

* Speech, language and communication skills
* Cognition
* Social and emotional status
* Health status and background
* Cultural background
* Education
* Contextual issues.

Select and organise this information using headings adapted from the International Classification of Functioning, Disability and Health (ICF) (World Health Organization, 2002). The headings are as follows

*A: Impairment* - includes describing speech & language skills, cognitive skills, description of main method of communication, associated medical factors, and developmental factors.

*B: Personal factors & environmental factors* - includes a person’s lifestyle, education, life events, race/ethnicity, and assets of the individual. Assets can be internal or external. For example an individual’s strengths may lie in personal factors such as motivation, determination and a positive outlook. Alternatively external factors may be external support or the communication skills of a partner. Environmental factors include considering the support, relationships and attitudes that are present in the environment in which people live and conduct their lives.

*C: Impact* - this includes activity and participation. Activity is the execution of a task or action by an individual. Participation is involvement in a life situation. Activity limitations are difficulties an individual may have in executing activities. Participation restrictions are problems an individual may have in involvement in life situations. See also McCloid and Bleile (2004).

*‘The profile organises all of the relevant information so that the therapist and client start to make sense of the communication difficulty in the context of the individual’s everyday life. It is informed by referral in the first instance and built on by what is revealed through evaluation and assessment*

*The therapist can look at the overall profile of the individual: what are the strengths including positive factors or resources that can be drawn on, and what are the difficulties or barriers that need to be addressed? It is also possible to make a judgment about the contribution of those around the client: does the environment need to be modified in any way? ’*

(Bunning, 2004: 10-12)

## Formulating Hypotheses

Please refer to the hypotheses document on BB SALT2002/SALT2207.

When you have considered all of the relevant data you need to consider what you understand by this information and develop some hypotheses about your understanding of your client’s disorder/s. This is called or clinical description diagnosis. Diagnosis or clinical description is useful because it helps us to identify patterns of difficulty and guides our thinking about what might help the client with their communication skills. You need to think about your client data and the signs and symptoms that your client exhibits and consider all of the possible hypotheses that are plausible and the reasons that you are considering these. Not all clinical descriptions lead to a definitive diagnosis but instead describe the key characteristics of the presenting problem. The reasoning behind your decisions is called the rationale.

### Planning intervention

For the purposes of the university assessment for SALT 2022 you will not be asked to present diagnostic and clinical descriptions not intervention decisions. However intervention will be considered in the SALT 2002 tutorials and **students must expect to plan and carry out intervention whilst they are in placement.** Practice educators are asked to assess students on this developing ability in the PEA in Outcomes 5-9. There is a suggested format for session planning given in the clinical placement guide.

When considering intervention planning you should consider the information that you have prioritised from the IP, your clinical hypotheses and diagnosis/clinical description. You will also consider what the client thinks and any relevant knowledge and theory –see below. This combined information forms the basis on which to plan intervention.

Every aspect of intervention with your client will need to be explained and justified. You will need to provide rationales.You will make reference to all of the client evidence which supports these decisions by referring back to the IP alongside drawing upon your knowledge and up to date theoretical evidence.

When planning to work with a client, check that you have considered the following questions:

* *Have I got all of the information that I need to start the intervention process?*
* *What will improve this client’s wellbeing and quality of life?*
* *Am I using the best possible knowledge and evidence base?*

A good start for reading about intervention is Chapter 4. Therapy: Process and Practice in Bray M, Ross A & Todd C (1999) Speech and Language: Clinical process and practice. London. Whurr Publishers

### Theory to practice – what does this mean?

At every stage in the clinical decision making process we need to use the speech and language specific knowledge taught at university and in books and journals. Theory is used at every step of the process from deciding whether a client needs to be seen by a SLT; to data collection, diagnosis, intervention; evaluation of the effectiveness of intervention, and discharge.

The subjects taught on this professional course will all have a place in practice. Sometimes it can be difficult to see the direct relevance of some of the lectures and different subjects will be more useful with certain client groups. It is also true that qualified and experienced speech and language therapists often find it difficult to say which ‘knowledge’ or ‘theory’ that they are basing their actions on, as they have assimilated the knowledge and experience to such an extent that unpicking it can be tricky. Students need to build a knowledge base but also to be able to apply this to thinking about their clients and making decisions about what to do.

When you are in placement always ask yourself what knowledge you need to draw on in order to understand what you are seeing and how this can be used to make decisions. The using of this knowledge is called applying theory to practice. A student’s ability to have understood and ability to apply this knowledge is the particular focus of the university element of assessment of clinical practice and is also assessed by practice educators.

An example of the breadth of knowledge and how it might be applied is given below. For example, when asked to decide the possible actions for a child referred to speech and language therapy presenting with unclear speech, you would need to draw on the following knowledge and skills (this does not give you every decision but gives an example of how theory might be used) and apply this to all aspects of the clinical decision making process.

|  |  |
| --- | --- |
| Assessment  Is this a case for intervention? How, and what should be assessed?  SALT 1209 SALT1211,SALT 1002,SALT 1003,SALT1007,SALT 2207  SALT 2000,SALT2002,SALT 2003,SALT2004,IPE | |
| Knowledge that could be drawn on:  The pathway of typical speech and language development    The pattern of typical child development  Anatomy and physiology- oral development and structure  Apply models of analysis and thinking –psycholinguistic model  Signs and patterns of communication disorders  Areas for assessment  Methods of assessment  Analysis of data collected  Knowledge and skills about how to engage and build a rapport with children and parents and  Clinical thinking and comparing to clinical experiences | Students would draw on their knowledge of what constitutes the “typical” development of communication, to make decisions about whether the child is delayed when compared to other children the same age, and if so, the extent of the delay  Knowledge is needed in deciding if this child is following a typical pattern of speech development or an unusual pattern.  Knowledge of child development and communication disorders would inform a decision about whether this speech disorder is the only communication problem or if it exists along with a language delay or additional factors such as, learning difficulty or a hearing problem etc.  It will also guide you to explore the status of the child’s other skills involved in speech production such as auditory discrimination, awareness of errors, oral structure and skills, etc.  Knowledge about which method of assessment to use, how to carry this out and what information will be yielded as a result. You apply your knowledge in deciding if this is this a case for formal or informal assessment? Which is the right test that will give the information that is needed both for diagnosis, information to others, and intervention choices for this child?  Drawing on knowledge about speech to interpret the significance of the data collected. This is vital for clinical decision making as intervention needs to be based on an analysis of the assessment findings. For instance if your data leads to a clinical description of phonological delay then the approach you will take will relate to that hypotheses by using phonological therapy that nurtures the child’s system rather than teaching new sounds (Fey 1992). If the child has difficulty with articulation; that is ‘making’ the sounds, then a different approach may be indicated and you would use your knowledge of phonetics and the theory underlying the approaches to articulation difficulties to decide how to help the child develop new motor programmes and patterns. (teaching new production of sounds)  Use knowledge to determine whether there is a more useful model that will help your understanding of the problem. (i.e. psycholinguistic model, Stackhouse and Wells, 2001)  Your knowledge about disorders will lead you to consider all the possible diagnosis (hypotheses) for this child and test for these appropriately. Can this child repeat the sounds he cannot say? Does he recognise error patterns in others? How much progress is he making? Do the signs and his responses lead to one hypothesis over another?  Being able to recognise patterns of disorder can help to predict the progress that might be made, or an approach to intervention that is effective for a particular client group etc. |
| Intervention  SALT 1209, SALT1211,SALT 1002,SALT 1003,SALT1007,SALT 2207, SALT 2000,SALT2002,SALT 2003,SALT2004,SALT2005,IPE | |
| Apply knowledge and skills to find out and decide:  What does my client want from intervention?  What interventions might be appropriate?  What is the evidence that we can be effective in making change?  To check that the right information has been collected and whether this is being used in the best way to make clinical decisions and that the intervention decision relate to the information that has been collected.  Knowledge about who could be involved in this child’s life and who could carry be effective in helping with intervention  Knowledge about learning and reinforcement in intervention | You will combine knowledge about speech disorders with your assessment information and knowledge about what the client wants in order to make intervention decisions. You will plan intervention using knowledge about all of the factors that affect learning such as memory, attention, effective methods of re-inforcement and praise, use of a variety of modalities, what is inspiring and motivating for this child to help you plan the best learning opportunities for the child. It will guide how often the child should be seen and where this should best take place, and knowledge of the staff best placed to carry out the sessions. For instance a child with a learning difficulty may need smaller steps, with more repetition, and work may need to be planned to support his development taking into consideration the national curriculum.  Knowledge of the value of working in partnership and with a variety of people, counselling skills etc. and being able to work with a variety of people is vital to the success of any therapeutic relationship. Parents or clients themselves often make choices about the direction of intervention  This knowledge combines to ensure that the intervention planned will be most effective and have the best chance of having the impact on the child’s life. This may include making an onward referrals as necessary ( such as for a hearing test for instance)  Knowledge about how information can be presented and shared will help when planning for intervention aims to be generalised. |
| Evaluation  Is my intervention making a positive difference to this child’s life?  Am I working in partnership with my client/carer?  SALT 2002, SALT1209,SALT2207 | |
| Knowledge about how these types of disorders might progress  Knowledge about outcomes measures  Knowledge about reflection and evaluation for client and self  Knowledge and skills about recording progress against aims | In order to know if your intervention is working you must use knowledge and skills to consider and reflect on the client’s performance and your own developing skills using skills and knowledge from topics of reflection and evaluative.  You may compare the child’s progress with your information gained from working with other children with similar problems and from the descriptions in the literature of the progress made of children with this condition.  You may need to use knowledge of outcome measures to collect data about progress for service audit and to contribute to the evidence base. |

And all this with well-developed personal skills in interaction, counselling and understanding any ethical considerations!! (see personal and professional development modules (SALT 2002, 1209, 1211)

Developing this speech and language specific knowledge base and the ability to use this to guide decision making, is the beginning of a lifelong commitment to continuing professional development. Professionals must keep up to date as new knowledge and approaches become available and all clinicians must collect information about the effectiveness of their interventions. All professions, not just speech and language therapy, are being asked to demonstrate that their services make a positive difference to people’s lives and looking at how this can be measured. For instance, if you go to the doctor with earache and are prescribed medication, you hope that he makes these decisions based on evidence that; this is the right treatment for your specific condition; the right amount of medication; for the right amount of time, and will be make a positive difference to the condition. Many elements of SLT intervention do not have this strong scientific evidence carried out by research studies on large numbers of people but there is a growing body of research about certain approaches where results can be measured and replicated. The process of developing strong body of evidence is still in its infancy and intervention is often based on the knowledge bases as described above, along with accepted clinical practice, which is based on the experience of effectiveness gathered from the profession. Experiential evidence is considered valuable and valid, but the profession is also seeking to broaden this to build a more “scientific evidence base”. (You will learn about different types of research and levels of evidence when studying research methods.) The development of this body of research is usually referred to as developing ‘Evidence Based Practice’.

**Building a strong understanding of the knowledge taught at university and applying this is the important first step in this process**

### Evidence Based Practice

You will hear the term ‘Evidence Based Practice’ (EBP) increasingly as you progress through the course. Evidence is generally thought of as proof which supports a claim or belief (Dobson and Wren 2013) and in clinical practice the triad of evidence-based practice is being increasingly used. This brings together; evidence relating to systematic research; evidence from clinical expertise; evidence of client preferences (Dollaghan, 2007)

A good starting point is to always consider, when you are giving a rationale for actions, to think about whether you can justify your decisions taking into consideration these three factors.

1. Clinical expertise. For students this is gained primarily through applying the knowledge learned at university as described above and real life experiences on placement with clients. Practice educators can also help by providing their expert knowledge of working with their clients and building a body of knowledge as they practise about what is effective and what they observe is effective in bringing about change for their clients.
2. Client preference refers to the choices and opinions that client or carer may have about what is important to them which may guide the choices of target decided upon
3. Evidence from systematic research comes from journals, the RCSLT research strategy (RCSLT 2006) etc.

See, “The Better Communication Research Programme” (BCRP, 2012) for an example for building an evidence base for children’s therapy;

<https://www.gov.uk/government/publications/what-works-interventions-for-children-and-young-people-with-speech-language-and-communication-needs>

An example of an evidence based intervention for adults is the Lee Silverman voice treatment.

<http://jnnp.bmj.com/content/71/4/493.short>

The Research Centre RCSLT website: http://www.rcslt.org/members/research\_centre/introduction

The Australian website speechBITE is a database of intervention studies across the scope of speech pathology practice. http://speechbite.com/

See Blackboard for further information about sources of evidence base and refer to subject specific lecture notes.

### Useful reading

Dollagahan, C.A (2007) The Handbook for Evidence- Based Practice in Communication Disorders. Paul H. Brooks

Dobinson, C. Wren, Y. (2013) Creating Practice Based Evidence. J& R Press

## university assessment Writing the Case Presentation- assignment SALT2022

In term 2 of placement students are asked to identify a client, in consultation with their Practice Educator, and to collect data on this client, in order to prepare this case presentation.

The client should be someone with whom the student has had the opportunity to observe, assess, or work directly or indirectly in the care of this client.

Students are also asked to be involved in an assessment activity which contributes to an understanding of a chosen client’s communication abilities and difficulties. (see page 36 for examples of suitable activities).

It is recognised that there are some occasions where the assessment may be best completed by a carer or parent. Students will include the assessment results from the tasks that they carried out in placement in Steps 1 and 2 of their case presentation but not the detail of the assessment task which will be presented in the viva.

Students must seek consent for use of the client information to be used in a case presentation via the form given on Blackboard or in the Practice Guide. Students must submit this consent form in a sealed envelope when submitting their case presentation paperwork.

Where possible, start this piece of work as soon as you begin working with the client that you have identified as the client for your case presentation. Some students will be working in situations where they do not see clients regularly,and in this case, may have less background information.

We recognise that students may see clients at any stage in their care pathway and this plan can be adapted for clients seen for initial appointments as well as those attending more regularly. It can also be adapted for students who are seeing clients in groups or who are carrying out training. If you in doubt about a situation contact Debbie Hunt or your clinical tutor for a discussion about the best course of action.

We have divided this process into are 6 steps to help students appreciate and follow all of the important elements in this process. Follow each step carefully. Label each step clearly throughout your work.

* Use the formats suggested; keep consistent formatting with clear subheadings. Use size 12 fonts, 1.5 spacing and Arial or Comic sans font. Add page numbers, student number as a header. The format for each section is given at the end of this guide.
* Read the case examples for each section to help you complete the plan. Case examples are in *italics* throughout this guide.
* Students must adhere to the rules about confidentiality and read the guidance given here carefully. They and students must also refer to the HCPC Code of Ethics for students and RCSLT guidance.

**Notes:**

### Students who are working with clients in a group

Students are advised to focus on one client wherever possible although if, for example, an observation of the performance of a number of clients to a group activity is chosen as the assessment, students may collect data about this one element across the whole group but consider the implications for their given client in their case presentation.

### Students working as peers

Students should wherever possible chose a separate client. However if this is not possible students should assess different elements of the same client where this is both appropriate and possible

### Students undertaking initial assessments

We recognise that many students will be in settings where clients are seen only for first appointments and students may not get the opportunity to see clients on a number of occasions. This case presentation can be carried out just as effectively with data from a client that has been seen once as for clients seen more regularly.

### Students working at a universal level or with non-referred clients.

This will usually apply to those students working with children, but may apply if a student is placed in a ‘social group’ such as a group for people with aphasia. Students may not have access to ‘medical’ or ‘SLT case history data ‘ in these cases but will be able to collect data from others in the environment of the client and use their observations as the assessment tool.

## CONFIDENTIALITY

Students are responsible for ensuring that their work meets the required standards of confidentiality. These guidelines apply to all written, verbal and digitally reported information on the course.

**Principles**

* People should not be identifiable from the information in any information held by a student. This applies to service users, their family and friends, staff and fellow students. Reference to people must therefore be modified to ensure that this is the case.
* Information can sometimes go astray. If in doubt, work on the basis that a report might be found by a member of the public. Similarly conversations about service users, colleagues, and work settings can be overheard.

**Practice**

* Do not refer to people by name or their initials. Use an appropriate pseudonym and state that this is the case early in the report.
* Do not refer to places by name, abbreviation or initials. Use a description instead. This applies to clinical settings, placement, workplace details, geographical areas, home addresses. For example you could write ‘a nursery in a rural setting’ rather than ‘Wildcat’s Nursery in Billhampton’
* Do not include dates of birth. You can include chronological age CA: 4;03
* Consider whether the sum of the information recorded (e.g. a rare condition, an unusual history, a distinguishing physical characteristic, an unusual job) might be enough to identify a service user or colleague.
* Be responsible for your belongings when carrying anything which contains sensitive materials. In particular this refers to transportation of digitally recorded data and consent forms acquired whilst on placement.
* Consent forms for video/ audio recordings must be stored, transported, and handed in contained in a sealed envelope
* Where possible use password and encrypted data sticks. Do not save any digital recordings on personal cameras, computers/smart phones and do not take extra copies of recordings for yourself.
* .Do not take any material/documents with service user information away from placement. This includes assessment forms.
* Video or audio recordings must only be used with due regard for the permission that has been given. DVDs or audio recordings must be viewed by the student in private and not shared with anyone not identified on the consent form.
* Identifying information must be removed from document effectively. Ideally information should be blocked by plain paper when photocopied or cut from the document. However if you use a black marker pen to cross out identifiable information ensure that the crossing out is made on both sides of the paper and ensure that information cannot be read when the paper is turned to the light.
* For some assignments you will be required to complete and submit a confidentiality checklist along with assignments. *All breaches of confidentiality in coursework are taken seriously and will result in reduced marks or even failed work. It is your responsibility to understand the issues and follow the guidance.*
* Do not discuss sensitive information regarding service users, colleagues, placement settings with anyone unless required to do so in relation to your learning on the course. If you do refer to such information then be aware of the setting, ensure that you cannot be overheard and consider how your comments might reflect on you and the health profession as a whole. It is inappropriate to make personal or derogatory comments about service users, fellow students or other health care professionals even if you are confident that you will not breach confidentiality. This applies to all interactions that you may have with colleagues (including on social networking sites).

For more information refer to:

* Communicating Quality 3 Guidance on Best Practice in Service Organisation and Provision (Royal College of Speech and Language Therapists, 2006). Section 1.76 <http://www.rcslt.org/speech_and_language_therapy/standards/CQ3_pdf>
* HCPC Confidentiality – guidance for registrants (HCPC, 2012) <http://www.hpc-uk.org/assets/documents/100023F1GuidanceonconfidentialityFINAL.pdf>

**De Montfort University**

**Speech and Language Therapy (SLT) Programme**

As speech and language therapy students you are expected to maintain the highest standards of professional behaviour and fulfil your legal and professional obligations with regards to patient confidentiality. Your assignments may contain sensitive information particularly if they refer to placement events.

You must always remove patient identifiable data from your work and consider whether the sum of the information recorded (e.g. a rare condition, an unusual history, a distinguishing physical characteristic) might be enough to identify a service user or colleagues.

By submitting this sheet with the assignment you are agreeing that you have done the following:

You have checked your work carefully and are confident that there are **NO** breaches of confidentiality

The assignment contains:

* **No** identifying information for *any* people/places/buildings/workplaces
* **All** names and places coded to ensure anonymity
* **No** date of births
* Pseudonyms clearly stated as such.
* **No** documents from placement

In relation to this assignment and related University work you agree that:

* You have no documents from placement in your possession
* You have no copies of any document/video/audio recording containing client data
* You have no digital files containing client date stored on a PC/lap top/Smartphone
* You have stored this information securely, and no unauthorised individual has been allowed to view/listen to this material

You understand that:

* Should my work breach confidentiality my mark will be capped or will be deemed a fail (see specific guidance for individual modules).
* Breaches of confidentiality where client data is compromised will be deemed a

issue for investigation under the heading of Fitness to Practice

**Student number:** Date:

Module Code & assignment title:

*Submit this completed form as the first page of your assignment*

## SUMMARY OF THE STEPS TO FOLLOW

## STEPS

These steps lead you through the process of clinical reasoning. This is where you collect data and ‘work out’ the strengths and challenges for the communication of a client, analyse this information and consider how this information will inform intervention planning decisions. We ask students to provide some ‘raw data’, in the form of a speech and language sample where appropriate, as it is important for tutors to see the information that students are using to make clinical decisions and to ensure that decisions are based on relevant and accurate data. This process is similar to collecting information in service using a case history and analysing the data for report writing and intervention planning. Please note that if you include copies of assessment data forms then you must ensure that there is no information included which will identify the client.

**Please state which assessment or therapy activity you are going to present in the viva at the beginning of your assignment**

## STEP 1

### 1.1 Relevant reported data

Information comes from a variety of sources in order to make sure that you have a complete picture of the communication difficulties to be addressed. This is called taking a ‘holistic perspective’. You must state where the information comes with dates (if your client is a child you will also need to show the age of the child at that point and date procedure and history for adults so that the timescales can be identified.) Note any gaps that you think are important by writing ‘not known’. You may use bullet points in this section.

The information needed in this section will depend largely on the individual. It may contain information that would be found in the client’s case history/notes. The following sub-headings would be typical but will vary depending on whether you are seeing a child or an adult, add in other relevant headings:

* Why this client been referred and by whom?
* Age of client in years and months ( **NOT** DATE OF BIRTH)
* Medical history/diagnosis
* Developmental history
* History of communication development
* Educational/Occupational information (current and history)
* Family history
* Impact – socially and emotional.

How is communication difficulties viewed?

How is it impacting on daily lives?

* Client/carer views

What the client’s/carer’s main concerns?

What does my client/carer want from speech and language therapy?

What are my client’s/carer’s best hopes for therapy in the long term?

* List all other agencies involved with this client? Include all relevant information about this
* Information reported from MDT team members

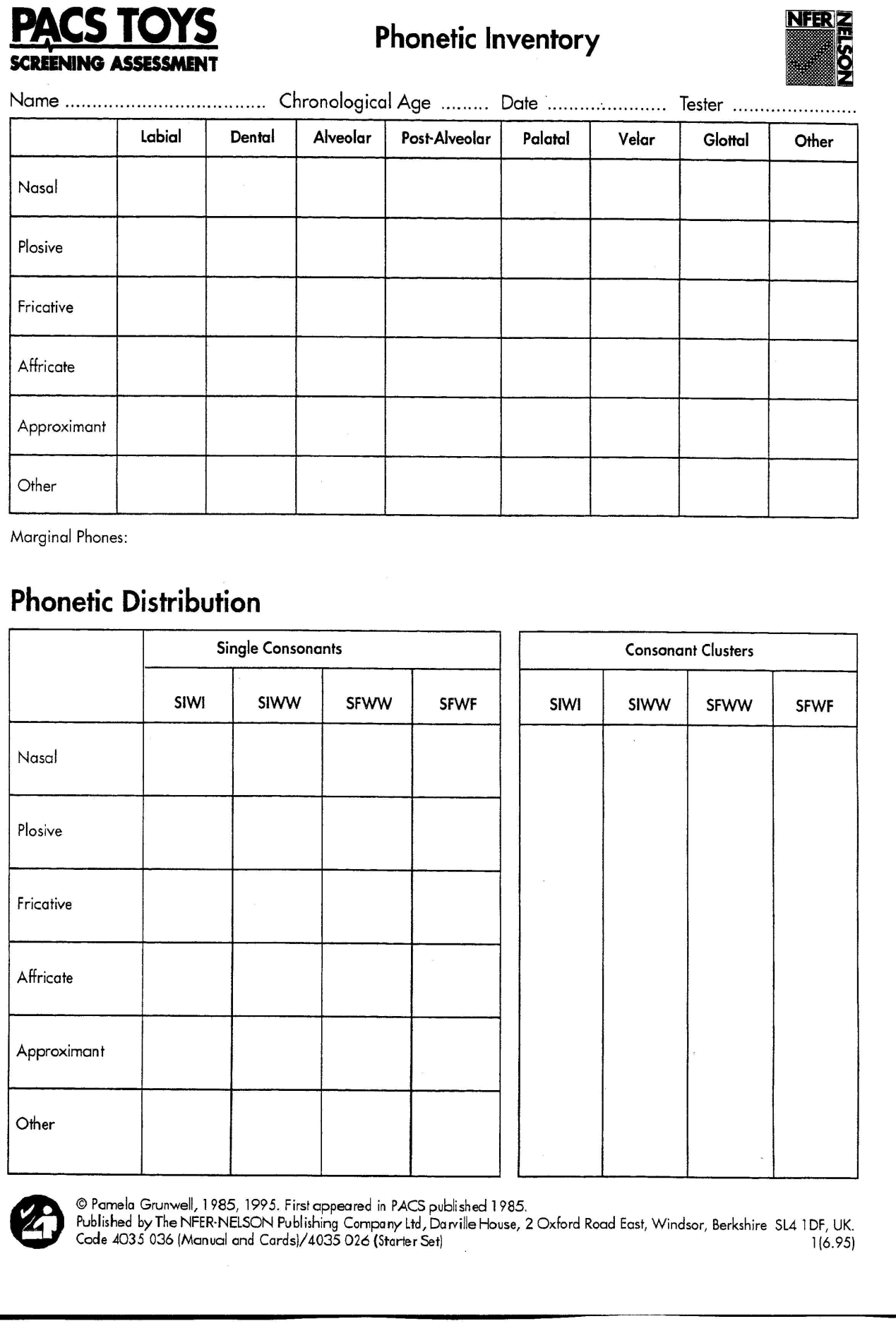
### 1.2 Assessment data and analysis

Students should include the assessment data results collected themselves and that has been carried out by others (if available).This will also include the assessment activity that will be presented for the viva. Please put a \* by the assessment that you are presenting in the viva. (if this is not appropriate please just state which activity you are presenting in the viva).The results of all assessment should be integrated and considered along with the progress made by a client. The amount and type of data available will vary between clients and their point in their care pathway.

|  |  |  |  |
| --- | --- | --- | --- |
| Assessment  Formal/informal | Age of client at point of testing | Summary of Results/main findings | Analysis of assessment data  ( historical data should be included **only** if relevant but recent assessment information should be included and must be analysed according to conventions and methods taught at university) |
| **Consider the following when thinking about your test results**  What has been learned about the client from these assessments?  As progress been made between assessment points?  Evaluate the quality of the information that you have obtained.  How robust are these results? | | | |

## 1.3 Speech, Language and communication samplesSpeech sample

You must include a representative speech sample. You must use appropriate phonetic transcription. Students should complete a PACS profile or similar and give examples of, and analyse all error patterns. The PACS profile is only given as a an example to remind students that they must give a phonetic inventory and distribution, but students can use data from tests other than PACs to complete these steps.

.****

### Language sample with summary of findings

Please note that there will be some clients where a speech and language sample is not necessary to an understanding of their condition e.g. voice clients. However a short description of their communication skills can be made but it may not be necessary to provide considerable detail.

For verbal clients present a representative sample of language (at least 10 utterances, conversation, a sample of words, speech sample, and short interaction). Please give both the questions and answers wherever possible. Analyse/comment on the sample using a relevant linguistic framework. The sample should support and illustrate your clinical thinking. You could analyse across the following linguistic levels but this will vary according to your client.

* Semantics (type of vocabulary, number of words, problems)
* Syntax (basic grammatical analysis using LARSP) & morphology (e.g. use of word endings)
* Pragmatics and social use of language

Students must refer to the appropriate assessment models from their lecture notes, and may use any relevant model of analysis over and above the examples given here if appropriate to building an understanding of their client ( conversational analysis for instance)

**Non-verbal clients or those with very severe communication difficulties**

For non-verbal clients or those with very severe communication difficulties please give a description of their communication or use a relevant framework such as Means, Reasons, Opportunities (Money and Thurman 1994) or any appropriate model used in service.

## CASE EXAMPLES reported information/assessment

**NOTE**: **Please note that the examples given in the different sections are for different clients**

This is an example of a completed “case history”

**Step 1.1: Client data**

*The following shows an example of information for S age 3;10 S was seen 6 months after being referred to SALT when he was 3;10. by family health visitor*

**Carer views**

1. *Family are very concerned about his speech and language delay and are aware that he does not always respond to speech especially when the television is on etc.*
2. *They are concerned that he might fall behind at school.*
3. *He often has a cold.*
4. *Mother is still concerned about hearing as he did not have a cold on the day of this last test*

**Medical history/diagnosis** Case history taken with S’s mother, father and older brother present

* *He has had reported history of hearing difficulty (failed two hearing tests)*
* *Hearing is within normal limit at present (audiology report dated at 3;0 but is still under review)*
* *Older brother had grommets fitted.*
* *Repeated colds and runny nose even in the summer.*
* *Faddy eater – likes strong flavours.*

**Developmental history**

* *Reached all developmental milestones within normal limits (walking 12 months)*

**History of Communication development**

* *Very quiet baby, little babble and slow to use first words but used to let people know what he wanted by pointing and gesture (driving car etc.)*
* *Slow language development.*
* *Mother can understand him but dad struggles from time to time and they feel he sounds ‘younger’ than other children, parents would like to know how to help.*
* *Progress is being made especially since school started but variable and he does not seem aware of his speech errors.*

**Educational/Occupational information**

* *Has attended nursery 5 a.ms and now in reception class at local school.*
* *School visit 31.08.01, child age 4; 00. Teacher reports that he was initially very shy when he started school but then gained in confidence quickly.*
* *He plays cooperative games with other children but does not always follow instructions in the classroom when given to other class as a whole. This can be variable.*
* *He is interested in books and colouring and loves playing football and Leicester City and Thomas the tank engine.*
* *His attention is good on 1:1 level and will cooperate for 45 minutes and he shows a high level of interest in adult-led activities.*
* *Teacher is concerned about his speech and intelligibility and inconsistent response to verbal instructions.*
* *He does not appear to remember new vocabulary for curriculum topics and his teachers worried that he is falling behind in some areas of the Early Years Foundation Stage, in particular speaking and listening.*

**Family history**

*Brother 8years now doing well at school has minor speech immaturity /f/ - /th/ but reading is well developed according to his mother. (Observed in clinic with brother on initial assessment). Father is a salesman and works away on occasional basis. Mother works in bank part time and helps at children’s school with key stage 2 children*

**Other Professional involvement**

* *Teacher – concerns outlined below, SENCO – has an Individual education plan and is included in TA led language groups.*

**Impact – social and emotional**.

* *Presently not a hindrance to his social development - he is popular and plays with a range of the other children who understand him.*
* *Concerns that he is missing content of teaching as he does not always appear to follow whole group activities and not enough support available in the classroom to reinforce his learning on an individual basis.*
* *Language not well enough developed to build on more complex concepts and there are concerns about his phonological awareness and beginning literacy.*
* *Attention in whole group activities can be lost and this can make him appear “naughty” at times.*

**1.2 Assessment detail**

|  |  |  |
| --- | --- | --- |
| Assessment  Formal/informal | Age at point of testing | Summary of Results/main findings  Are the test results reliable? What has been learned? |
| *Preschool Language Scales* | *3;11* | *Age Equivalent score 2.9 years*  *Standard Score 80 ( between 1SD and 2SD)*  *Difficulties with pronoun ‘your’*  *Confused concepts ‘bi’ and ‘little’*  *Answers what and who questions but no use of possessives*  *Uses 3 and occasional 4 word sentences mainly nouns, omits verbs and prepositions (see language sample for detail)*  *Based upon previous informal observation this was lower than expected and was variable performance as child distracted* |
| *Derbyshire Language Scheme* | 3;11 | *He will often use vocabulary that he does not understand when included in an instruction.*  *Accurate at a 2 WL. At 3WL errors with verbs, adjectives, negatives. Some errors appear related to length of utterance.* |
| *STAP* | 3;11 | *Immature processes still used: fronting WF, consonant cluster reduction with all blends* |
| *Observation in school* | 4;00 | *Sociable child with other children plays in playground in organised games such as “chase”*  *Tends to watch and follow other children when given an instruction such as “boys – fetch your coats now.” Much better in one to one with teacher. Became fidgety during whole group sessions such as story time.* |

**1.3 Language and speech sample**

***Speech Sample:***

**Analysis of STAP2 assessment for FW at 3.11 years**

Good communication skills with a lot of progress noted.

Phonetic inventory [p, b, t, d, g, m, n, ŋ, f, ð, s, ʃ, ʒ, tʃ, dʒ, l, ɹ, w, h, ç, ɵ, pl, bl, bɹ, tɹ, dɹ, sl, ps, nd, mp, ts]

Normal developmental processes: fronting of velars, stopping of fricatives, gliding of approximants and some fricatives, reduction of s+consonant clusters, palatalization of fricative /s/. Epenthesis occurring in some final syllables such as *plate* realised as [pleɪjət] and *train* as [tɹeɪjən].

Structure: Syllable structures CV, CVC, CVCC, CVCV and CVCVC are realised correctly in most cases, with some evidence of epenthesis in final syllables. Initial clusters in the form obstruent + approximant are mostly present, allowing CCV, CCVC and CCVCV structures and one CCVCVC word.

Processes:

* Fronting /k/ to /t/, eg. *cars* → [tɑz], *coat* → [təʊt], with one correct realisation of the voiced velar /g/ in *girl*
* Stopping of fricatives /f, ɵ, s/ to /t/, eg. *finger* → [tɪndə], *thumb* → [tʊm], *sun* → [tʊn] and /z/ to /d/, eg. *zip* → [dɪp]
* Fricative /ʃ/ is partially stopped to the affricate /tʃ/, eg. *shoes* → [tʃujəz]
* Gliding of approximants /ɹ/ to /w/ and /j/ to /l/, eg. *red* → [wɛd], *yellow* → [lɛləʊ] with one correct production of /ɹ/ in *rocket*
* Gliding and devoicing of voiced labio-dental fricative /v/ to voiceless dental fricative /ɵ/ in *van* → [ɵan]
* Initial cluster reduction of all s-clusters other than /sl/ and /sw/ which were realised as /fl/ and /tw/ respectively. Some cluster reduction combined with other processes, such as /sk/ reduced to /k/ then fronted to /t/, in *sky* → [taɪ]. Two s‑clusters not reduced: /sl/ realised correctly in *sleeping*, while /s/ in *swimming* was stopped to the plosive /t/ → [twɪmɪn].
* Fricative + approximant clusters /fɹ/ and /ɵɹ/ showed substitution of fricative with plosive /t/, while median approximant in /fɹ/ was also substituted with labio-velar approximant /w/, so *frog* → [twɒd] and *three* → [tɹi]. In contrast, labio-dental fricative /f/ in /fl/ was substituted with alveolar /s/, ie. *flower* → [slaʊwə]

**1.3 Language sample with summary of findings**

P is 6.5 years. P has intelligible speech. He uses simple sentences structure and is joining sentences together. Features evidence of LARSP stages 1V to V, need further sample. Grammar follows typical pattern but problems with vocabulary or word finding. Uses questions, statements.

***Picture description***

*Q: What’s he doing next?*

*P: /he’s going in the bath now/*

***Clause level****: SVA (Locative and temporal)*

***Phrase****: Pron. Aux V. PDN. Adv*

***Word level:*** *Pronoun use. Auxiliary. Verb. Prepositions and Determiner*

***Q:*** *Who do you think is coming next?*

*Peter : /he’s coming. When is he coming? /*

***Clause level****: SV/QSV*

***Phrase level****: Aux pron V*

***Word level****: Aux. be + present part.*

**Spontaneous speech**

Q: Where did you go on Saturday?

P: I went to the big McDonalds up town and I saw a clown

Clause level: SVA c SVO

Phrase level: Pron P D N Adj N Prep N Pron Det N

Word level: past particle of “to go” and “to see”

Q: What is happening at Christmas?

P: /Well we got to that place and have dinner and then we do that game/

Notes: He some “empty” language with non- specific vocabulary especially for less frequent nouns or in response to open questions.

|  |  |
| --- | --- |
| **Reason** | **Example** |
| Requesting.  Wants/Needs  Attention | Asking for the Buzz Light-year toy in the classroom, bus in the AAC room. He will use eye contact to ask permission e.g. to press the music buttons in the corridor.calling people’s names to gain attention. |
| Protesting | Not taking a turn in the classroom.  Turning his head from a person, toy etc. |
| Greeting | Will say hello/bye to a variety of people at the appropriate times. |
| Choices | Will choose a lunchtime activity from a forced alternative. |
| Feeling | Will express feelings when playing using facial expression and actions on objects. Expresses happiness and excitement through singing and performance. |

**MEANS, REASONS AND OPPORTUNITIES**

Child with complex needs aged 10 years

Some non or weakly contingent utterances in longer conversations. Some involvement of comprehension, or memory.

**Example of Means, Reason, Opportunities Model**

L demonstrates a variety of means of functioning. He is able to communicate his needs using non-verbal cues such as moving to the item he is requesting within the room and signing “thank you” and will also use gestures such as mimicking feeding a baby or pointing in order to make his wants/needs known. He will use eye contact and facial expression occasionally in order to request permission, for example to pick up a toy, or look to an adult for confirmation that he is doing as is expected of him, for example when moving to another classroom, he might look back for confirmation that he is going in the right direction. Occasionally L will use Makaton, either as a standalone form of expression or to support one word utterances.

L has demonstrated that he is motivated to communicate for a variety of reasons:

* L is reported by many teachers (case notes), to be a very outgoing character who will always say hello in the corridor and who loves to ‘sing’ and ‘perform’ for people. This further demonstrates her motivation to communicate.
* L’s opportunities to communicate are often facilitated by those around him. At school and at home, those surrounding L know him well and are able to be an active communication partner taking into consideration his language level, ability and interests, enabling L to be an equal communication partner. L is reported to initiate interaction with family, familiar adults, peers and strangers highlighting the opportunity he has to interact. Observations of V at school indicate that he enjoys all opportunities to interact, turn take and share communication with those around him and although his social network is reported to be limited, factors such as allowing time and communication strategies are well facilitated within these environments further promoting L’s opportunity to communicate.
* The means, reasons and opportunities are intrinsically linked factors of equal importance (Abudarham and Hurd, 2002) which support one another. Reported information and observations of L indicate that there is a balance within these communication factors, particularly at school, suggesting that there is an appropriate amount of opportunity for L to communicate and that he has a level of motivation and means of doing so; his communication is functional.

## Step 2: Create and present an individual profile (IP)

This section is designed to help you begin to ‘sort out’ and organize the client data in order of relevance and priority. There should be **no new** information in this section – it should all be taken fromthe data collected in your case history.

Use the format given

i) Identify the pertinent client data from *your workbook* and map it to the following three IP headings:

*A. Impairment, B. Personal Factors & Environmental Factors, C. Impact.*

ii) Label each point on the profile so that you can make reference to them later (e.g. A.1, B.2)

iii) Label potential strengths and weaknesses. Strengths (S) are factors that might enable the client to progress. Weaknesses (W) are factors that might impede progress and may need to be addressed or overcome. In this section you will need to be able to explain why you have decided that each piece of information is a) relevant and b) labelled S or W

iv) Identify missing information. Do this by carefully considering what other information is needed to further your understanding of this client. Explain briefly how this information could be obtained. This will include all missing assessment information with a brief note about how this information might be acquired e.g. which test is required. Think about your client holistically – it is like completing a jigsaw – what pieces of the jigsaw are still missing?

## Case example individual profile

|  |
| --- |
| *A.Impairment (S)*  *A1.Hearing status: passed previous hearing test*  *A2. Unremarkable birth/developmental history/health*  *A3. Pragmatics: in clinic appropriate on meeting therapist, eye contact/smile/question/comments/volume, voice quality*  *A4. Expressive language: 3-4 word utterances, some use of ‘and’*  *A5. Initial oral observation: symmetry/saliva control/no slurring*  *A6 Ability to move tongue, lips, and copy non speech movements accurately*  *A7.Comprehension: responds to conversation*  *A8. Vocabulary: snake, caterpillar (with support)*  *A9. Syntax: use of past tense*  *A10. Phonetics: k, d, n, nt, b, vowels in words*  *A11. Phonology: b, n, K (1 x in WISI)*  *A12. Can imitate adult model of /s/ /k/*  *A13. Error pattern consistent*  *A14. Recognises errors in others when faced with own error pattern*  *A15. Discriminate between own errors at word level in minimal pairs /k/ v/d/ and /s/ v /d/*  *A16. Progress with overall intelligibility – some development of fricatives WF*  *Impairment (W)*  *A11. Has frequent colds and earache*  *A12. Observation: Sound substitutions s- d, k – d, (difficulties with multisyllabic words, some final sound deletion, use of glottal*  *A13. Fine motor control immature: pencil hold/ immature picture/ lack of hand dominance*  *A14.Dislikes having his speech corrected* |
| *B Personal & environmental factors*  *B1. Parents supportive; attend clinic appt (S)*  *B2. SENCo involvement: they originally made referral to SLT(S)*  *B3. Siblings have no SLCN (S)*  *B4. Enjoys school but is reported to be shy (S)*  *B5. Difference of opinion re SLCN between parents (W)*  *B6. Two older siblings sometimes speak for her to interpret with unfamiliar adults (S & W)*  *B7. Familial background: Father has dyslexia (W)* |
| *C. Impact on activity and participation*  *C1. Not sure if she can follow all instructions - Dad reports (S)*  *C2. Has difficulty making herself understood with adults at school (W)*  *C3. Parents can understand her most of the time but have difficulty when she is talking about something that has a happened during the school day, it can take them time to tune in (parent reports) (W)*  *C4? difficulty following instruction at home, ‘forgets’ ‘not listen’: Mum reports (W)*  *C4 Parents ask her to repeat herself and think that she can improve her speech when she tries (S & W)* |
| *Missing information*  *Recent hearing test/explore sound issues/non verbal skills/IQ? – need more information from GP/health visitor*  *Need phonological assessment update e.g. STAP and psycholinguistic profile, oral assessment, identify core vocabulary*  *Need to find out what other strategies people use to help S when she is talking*  *Follow up her attention levels & comprehension at home and school*  *Home/daily lifestyle, play/interests – need more detail from parents*  *Parent aspirations for child, motivations, their priorities, commitment*  *Find out about communication environments - home, school ++*  *Need information about academic impact – early literacy development, speaking and listening in class, social development at school*  *Social and emotional factors - insight, impact, friendships, confidence, motivation* |

## Step 3: Clinical description/diagnosis of client’s speech, language and communication difficulties

Providing a clinical description or diagnosis is involved with classification. We use diagnostic skills in order to find out a client’s communication difficulties. SLT’s form clinical description and diagnoses or communication problems;

1. Whether a disorder is evident
2. The characteristics of the disorder
3. Whether the client should be evaluated further
4. What kind of disorder is present, as compared to a variety of other possible disorders when the signs and symptoms and assessment evidence is analysed (this is called differential diagnosis- differentiating between the possible options suggested by the data)

The first step is to generate a series of possible *clinical hypotheses* about the client’s communication difficulty by reviewing the IP.

### Information about generating clinical hypotheses.

Generating clinical hypotheses helps you work towards a clinical description/diagnosis for your client’s speech, language and communication difficulties. Consideration of the data also enables you to gain a deeper understanding of your client’s difficulties so that it leads to clearer on-going assessment and intervention objectives.

So, first you must consider the evidence from the client data and the IP that you have created in order to draw from this some potential clinical hypotheses. You are aiming to consider this evidence from the IP as well as knowledge of SLCN for each potential hypotheses and this will lead you to build information and then accept or reject each hypotheses so that you can arrive at the most likely or sensible clinical description/diagnosis for your client at this point in time.Hypotheses are made pre-and post-assessment and may change as you are revised throughout your dealings with a client.

Include hypotheses according to the following headings (where relevant):

* Nature of impairment
* Severity of impairment ( sometimes this is inherent in other hypotheses)
* Impact of impairment on activity and participation

**Missing information.**

You may not have enough information at this point in time to draw any firm conclusions and this will clearly direct you to collecting further data. Please state what is missing and how this can be collected

**Statement(s) about causal and maintaining factors** This will usually be a diagnosis made by another member of the MDT team such as a medical diagnosis e.g. CVA, or Parkinson’s disease, or cerebral palsy. SLTs may also have hypotheses about cause e.g. suspected hearing loss or the influence of the environment.

Example of all of the possible clinical hypotheses identified for P at 7.2 years (this includes more than one aspect of a communication difficulty, for example speech and language and learning). Hypotheses may or may not always lead to diagnosis but may instead form a description of the characteristics or severity of the disorder.

## Case example of hypotheses

|  |  |  |  |
| --- | --- | --- | --- |
| **What are all my hypotheses** | **What is my evidence for these hypotheses** | **What is my evidence against these hypotheses?** | **What information is still needed?** |
| **Causal/maintaining factors** |  |  |  |
| 1. *P has a speech disorder secondary to a hearing problem* | *History of glue ear and repeated failure of hearing tests in early years* | *Progress being made and parents had no concerns regarding hearing earlier at that period* | *Acquire recent hearing and ENT test results* |
| **Nature of Impairment** |  |  |  |
| 1. *P has an articulation disorder* | *P produces /s/ as interdental*  *He cannot repeat sounds with adult model*  *At times he uses unintelligible speech*  *Use of epenthesis* |  |  |
| 1. *P has a childhood dyspraxia* | *P makes inconsistent errors particularly in the structure of newly learned words* |  |  |
| 1. *P has a motor speech disorder* | *P dribbles constantly and uses a very “anterior tongue position , mainly on /s/ but on some other sounds* |  | *Have not assessed oral structure*  *Information needed on hearing and ENT report on tonsils and adenoids* |
| 1. *P has delayed phonological development* | *J is making fronting, stopping and final consonant deletion errors which should have been resolved by age 5.8 ( Bowen, C)* |  |  |
| 1. *J has a phonological disorder* | *P has made very little progress in the last year (Dodd, 2007 )*  *J is making errors which do not follow a developmental pattern*  *J is making inconsistent errors*  *(Grunwell) ( Dodd) ( Holm, Crosbie and Dodd, 2007)* |  | *What are his phonological awareness skills?*  *Can he discriminate recognise errors in others speech?*  *Is he aware of his own errors?* |
| *Language difficulties* |  |  |  |
| 1. *P has delayed language development* | *Language is developing at a slower pace than typical*  *Expressive language difficulties affect vocabulary, grammar and morphology*  *Slow start to language development* |  | *No recent formal language assessment.* |
| 1. *P has specific language impairment* | *P has word retrieval difficulties Problems with grammar*  *Comprehension is delayed (Fey et al. 2003)*  *Late talker* | *Vocabulary seems delayed from observation* | *No recent formal language assessment.* |
| *Severity of Impairment* |  |  |  |
| 1. *P has severely delayed speech and language skills* | *Language skills are significantly behind other age matched children( Bishop, 1997)*  *Language is developing at a slower pace than typical*  *J is making fronting, stopping and final consonant deletion errors which should have been resolved by age 5.8 ( Bowen,C) This would be considered a severe delay* |  |  |
| *Impact of difficulties* |  |  |  |
| 1. *P’s communication difficulties are having an impact on his literacy* | *General difficulties with learning at school reported by parents*  *P not identifying written words in clinic ( observation)*  *Link between literacy and language learning (Rose 2006) (Snowling and Stackhouse, 2006)* |  | *Need to obtain school information*  *Also need educational information on cognitive skills, visual memory etc.* |
| *P ‘s communication is having an impact on his ability to access the curriculum* | *Children with severe language difficulties often have problems processing verbal information, making it difficult to process lengthy instructions ( Adams, J.W., Bowyer-Crane, C.A, and Snowling, M.J, 2006)* |  | *Need to formal assess language and observe in class room and collect data from teacher.* |
| *P’s difficulties are having an impact on his ability to make friends* | *Children with SLCN problems are at risk if social and behavioural difficulties (Botting , N., 2006)* | *Presently he is described as sociable and happy and has a “lot of friends”* |  |

## Step 4

Summary and conclusions:

Using the data and information that you have gathered about your client, and your analysis of this data, write a summary and draw some conclusions to demonstrate your clinical thinking at this point. Use the guide questions and statements

* Describe your client and summarise the key information about their everyday life.
* Reason for the referral and setting where your client has SLT. Include the amount in time of previous therapy and contact with other services.
* What are the influencing factors-
* What is your conclusion about the differential diagnosis/description for this client? What are your reasons for these thoughts? Has progress been made? What else may you need to investigate/gather information about to inform this?

This summary will also form the basis of the clinical decisions about intervention for this client.

## Case example summary and conclusions

|  |  |  |
| --- | --- | --- |
| **Name:** *J* | **Age**: *6; 0* | **Setting**: *Mainstream school* |
| 1. **Describe your client and summarise the key information about their everyday life.** *J lives at home with his parents and two older brothers. He attends local mainstream school full time. He speaks English with his family and is described as being talkative and energetic. He loves playing with construction toys, Super Mario for PS 11, watching Dr Who and drawing. He spends time at weekends with children who are friends of the family. The families socialize together when they visit the park, swim and play football. He sees both sets of grandparents regularly at weekends. J talks a lot and mostly his family can follow him but he can get frustrated when people fail to understand him. He sometimes refuses to repeat himself and will often walk away from a conversation. With new people he can appear shy.* 2. **Reason for the referral and setting where your client has SLT. Include the amount in time of previous therapy and contact with other services.**   *J was referred by his health visitor at 3; 0 as he was using 2-3 words together and his speech was difficult to understand. He had an SLT assessment at 3; 06 and then had 3 blocks of therapy at his community clinic. Each block consisted of 8, 1/2 hour sessions. His mother attended each session and on one occasion a teaching assistant also attended. He has an Education, Health and Social care plan which is reviewed annually.*   1. **What is your conclusion about the differential diagnosis/description for this client? What are your reasons for these thoughts? What else may you need to investigate/gather information about to inform this?** *J presents with a developmental delay in the development of his phonological processes and he continues to use the following error patterns - stopping of fricatives and the omission of word final consonants. This is reported to be impacting on his ability to make himself understood when talking with adults. The pattern of his speech difficulty, the medical data and his reported problems with repeated ear infections indicates that a hearing difficulty may be an underlying contributing factor. Whilst his speech pattern has features of a delay, some factors; namely the severity and lack of progress, may indicate a persisting speech difficulty or developmental verbal dyspraxia. Furthermore there is a risk that if this difficulty were on-going it has the potential to impact on his literacy development. All of this information is subject to further investigation in order to rule out a persisting speech difficulty such as phonological disorder or developmental verbal dyspraxia.* | | |

## Step 5 References

Present a list of all of the references that you have used. Use Harvard referencing conventions. This section is not included in the word limit

These are the ones used in preparing this handbook (excluding references used in case examples)

Bunning, K (2004) Speech and Language Intervention, Frameworks and Processes. London. Whurr Publishers.

Bray M, Ross, A. & Todd, C. (1999) Speech and Language: Clinical Process and Practice. London.

Grunwell, P (1982) Clinical Phonology. “2nd edition. Croom Helm, London &Sydney.

Kerner, M. and Wright, J. (2001) Speech and Language Therapy: The decision-making process when working with children. (Eds.) London. David Fulton Publishers.

Metcalfe, M. (2010) “Ekos – a SMART solution”, Speech and Language Therapy in Practice. Spring 2010

McAllistair. L and Lincoln, M. (2004) Clinical Education in Speech –Language Pathology. Methods in Speech and Language Pathology. London. Whurr.

McCloid, S and Bleile, K (2004) The ICF: a framework for setting goals for children with speech impairment. Child Language Teaching and Therapy 2004; 20; 199

Money, D. and Thurman, S ., 1994, Talk about communication Bulletin of the Royal

College of Speech and Language Therapists, April, 12-13.

Tomblin, B. Morris, H. & Spriestersbach, D.C (2000) Diagnosis in speech and language pathology. 2nd edition. San Diego. Singular Publishing.

World Health Organisation (2002) Towards a Common Language for Functioning, Disability and Health ICF. Geneva. World Health Organisation from <http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf> [accessed on 18.01.11]

## Step 6 University Assessment

## Case presentation/Viva preparation

**Step 6.**

**What is needed for this assignment?**

Students on placement are asked to identify a client, towards the middle to end of term 2, in consultation with their Practice Educator. The client should be someone with whom the student has had the opportunity to observe, assess, or work directly or indirectly in the care of this client. Students are asked to carry out some form of ‘assessment’ with this client/carer which contributes to an understanding of a chosen client’s communication abilities and difficulties (see below for examples). It is recognised that there are some occasions where the assessment may be best completed by a carer or parent.

Students must seek consent for use of the client information to be used in a case presentation via the form given on Blackboard or in the Practice Guide. Students must submit this consent form in a sealed envelope when submitting their case presentation paperwork.

Students will include the assessment results from the tasks that they carried out in placement in Steps 1-5 of their case presentation but not the detail of the ‘assessment’ task which will be presented in the viva.

Students will prepare and present their case in two ways.

1. By preparing a case presentation on the chosen client following the steps in the ‘Case Presentation Handbook’ (see above) Steps 1 to 5.
2. By presentation with regard to an aspect of assessment on the same chosen client during a viva held at the university. This viva is carried out with 2 university tutors: a marking tutor and an observing/ moderating tutor. An external examiner may be present in some of the vivas.

This assignment has 2 hand-in dates.

* **Hand in 1.** Students will prepare the plan steps 1 to 5 inclusive and submit this via Turnitin on Blackboard which will be marked by our designated tutor. See Blackboard for hand-in dates and tutor allocation. Students will receive comments, feedback and a guide mark available via Turnitin. Student’s marks may change by one banding (up or down) after their viva from this initial grading.
* **2 set Questions.** Students will be set two questions about their case to prepare in advance of the viva based on this initial case presentation. The questions are designed to lead students to a deeper understanding of the client and theory and to guide their thinking around their case. Students may be asked to re-write a section of their case but only if this forms part of one of the questions asked by the tutor. The marking criteria is available on Turnitin.

**Hand in 2**. (The viva) Students will assemble their presentation (following the guidelines) and prepare the answers to their 2 set questions. Students may bring materials and notes into the viva to illustrate their learning. It is also advisable to bring a reference list of any additional references used when preparing the answers to the set questions. Students will be allocated a final grade after the viva which is a combination of the paperwork, response to questions and the presentation. This mark can be one band difference (up or down) from the initial marking.

### What kind of assessment is suitable?

This data collection can be interpreted broadly to suit the particular clinical context and could be any of the following;

1. A formal assessment (or part of an assessment).
2. Informal assessment of one or more element, or baseline measure. For instance single word comprehension, oro-motor assessment, establishing a baseline of sound production prior to therapy, bedside assessment for eating, drinking and swallowing. Student may design this assessment or use material available.
3. Diagnostic therapy. A session where measurement of a client’s performance during therapy establishes areas of competence on the task (this applies to all typical therapy sessions). Students must have a clear protocol for collection of this data. For instance if semantic cuing is used to support word finding students must clear ideas about which words are presented, in which format, how regular the cues, and record the client’s responses so that accurate data can be recorded.
4. Observational checklists. The student may be asked to design (or use commercial material) a checklist that covers one or more elements of a client’s communication difficulty. This may be used with an individual or a group.
5. Evaluating a client’s ability to use AAC. This may be to contribute to an initial assessment to see if the client is suitable for AAC or an evaluation of the success of communication using the device.
6. Gathering information from a parent or carer or from an MDT team member etc.
7. **Students undertaking initial assessments**

We recognise that many students will be in settings where clients are seen only for first appointments and students may not get the opportunity to see clients on a number of occasions. This case presentation can be carried out just as effectively with data from a client that has been seen once as for clients seen more regularly.

1. **Students who are working in groups.**

Students are advised to focus on one client wherever possible. However it is possible to choose the ‘group’ as the client and give an outline of the group characteristics and then evaluate the individual responses to one given group activity. Please speak to Debbie Hunt if this second option is considered.

1. **Students working as peers**

Students should wherever possible chose a separate client. However if this is not possible students should assess different elements of the same client if appropriate to the situation.

1. **Students working with universal or non-referred clients**

Students working with children at a universal level of service delivery or with non-referred clients are likely to have more observational and reported data. This is considered as valuable as more formal assessment data.

## The viva protocol

The vivas are carried out by two university tutors; the marking tutor, who will already have marked the work and offered feedback, and a tutor who will moderate the mark. The vivas will be audio recorded for moderation and equality purposes and, occasionally, live viva may be observed by an external examiner, or be reviewed at a later date via the audio tapes and examples of the case presentation paperwork. The dates and tutors are posted on BB.

**Part 1: The Presentation (up to 10 minutes)**

Students will present for 10 minutes (they may bring examples of work if appropriate) it is not necessary for this to be a formal presentation using power point but students must be organised and prepare under the headings given below. This section is timed as presenting cases in a succinct and accurate manner is part of professional life that is carried out by qualified therapists in case conference and in supervisions sessions.

Please follow this guidance

* Explain how and why this is an appropriate assessment for this client
* How had it been introduced to the client or how employed to collect information
* Describe and present the ‘assessment’ activity and rationale
* Identify the pros and cons of the assessment procedure/ process
* Explain what you have learned from the assessment results and how this, combined with other data collection results has helped you to formulate hypotheses about clinical description and the next steps for the client
* How was the result of this assessment ( and others) explained to the client/carer/MDT member
* Identify one personal development target for themselves arising from placement, or this activity and outline your development plan against this objective.

Tutors will be looking for evidence that students have

* An understanding of the purpose and process of the ‘assessment’
* An ability to present findings and to describe data
* Have an ability to interpret findings
* An ability to integrate the information from different sources of data
* Generate sensible hypotheses
* Have an ability to discuss draw sensible conclusions
* Are able to identify the consequences of the assessment data for future decisions for their client
* Can reflect on placement experience for the benefit of their client and their own development
* Can draw on relevant knowledge and apply this to the clinical decision making process
* Ability of students to report their evaluation orally and in writing

**Part 2: Viva Questions**

This is the section of your assessment where your marking video tutor will ask questions to further explore your understanding.

* **You will be asked the two questions that have been identified in your feedback.**
* **Tutors will ask one additional unseen question.**

Students are expected to carry out reading prior to the viva to support the answers to their questions. **Answers to the prepared questions should not usually exceed 8 minutes per question.** Students may bring any materials to illustrate their answers but not electronic equipment or telephones.

Tutors will only ask the 2 set and 1 unseen question but may prompt for further information using

1. General prompt (GP). “Is there anything further you would like to add?”
2. Scaffolding prompt (SP) which seeks additional information to explore the student knowledge or re-direct the student’s answer.
3. Re-phrase prompt (RP) in circumstances where the student has not understood and where the tutor judges that ambiguity in meaning has arisen as a result of the way the question has been phrased by the tutor.

Tutors will take into account the amount of prompting (1 and 2 above) when calculating the grade in order to ensure equitable marking.

The following are topics are aspects that may be the focus of questions;

* clinical description and diagnosis
* theory which underpins your decisions and the case presented
* the client and their case management
* client group/clinical setting
* partnership working
* related areas of theory and clients
* service provision including inter-professional working
* intervention planning

Your marking tutor will typically ask the questions but may ask the observing tutor for comments if necessary.

**The viva is brought to a close after the questions**

**Information about grades**

Students will receive written feedback and a final grade via Turnitin after the moderation process and consultation with the external examiner has taken place.

# TEMPLATES

## These are given to help students present the plan in the given format

**State which assessment/ activity you will be presenting in the viva**

**Step 1 Client Data**

You may use bullet points. State where the information comes with dates (if your client is a child you will also need to show the age of the child at that point). Note any gaps that you think are important by writing ‘not known’.

**1.1 Relevant reported data**

The information needed in this section will depend largely on the individual. It may contain information that would be found in the client’s case history/notes. The following sub-headings would be typical:

* Age of client in years and months ( **NOT** DATE OF BIRTH)
* Medical history/diagnosis
* Developmental history
* Educational/Occupational information (current and history)
* History of communication development
* Family history
* Impact – socially and emotional.

How is communication difficulties viewed?

How is it impacting on daily lives?

* Client/carer views

What the client’s/carer’s main concerns?

What does my client/carer want from therapy?

What are my client’s/carer’s best hopes for therapy in the long term?

* List all other agencies involved with this client? Include all relevant information about this

**1.2 Assessment detail**

Think about what has been learned from these assessments

Evaluate the quality of the information gathered

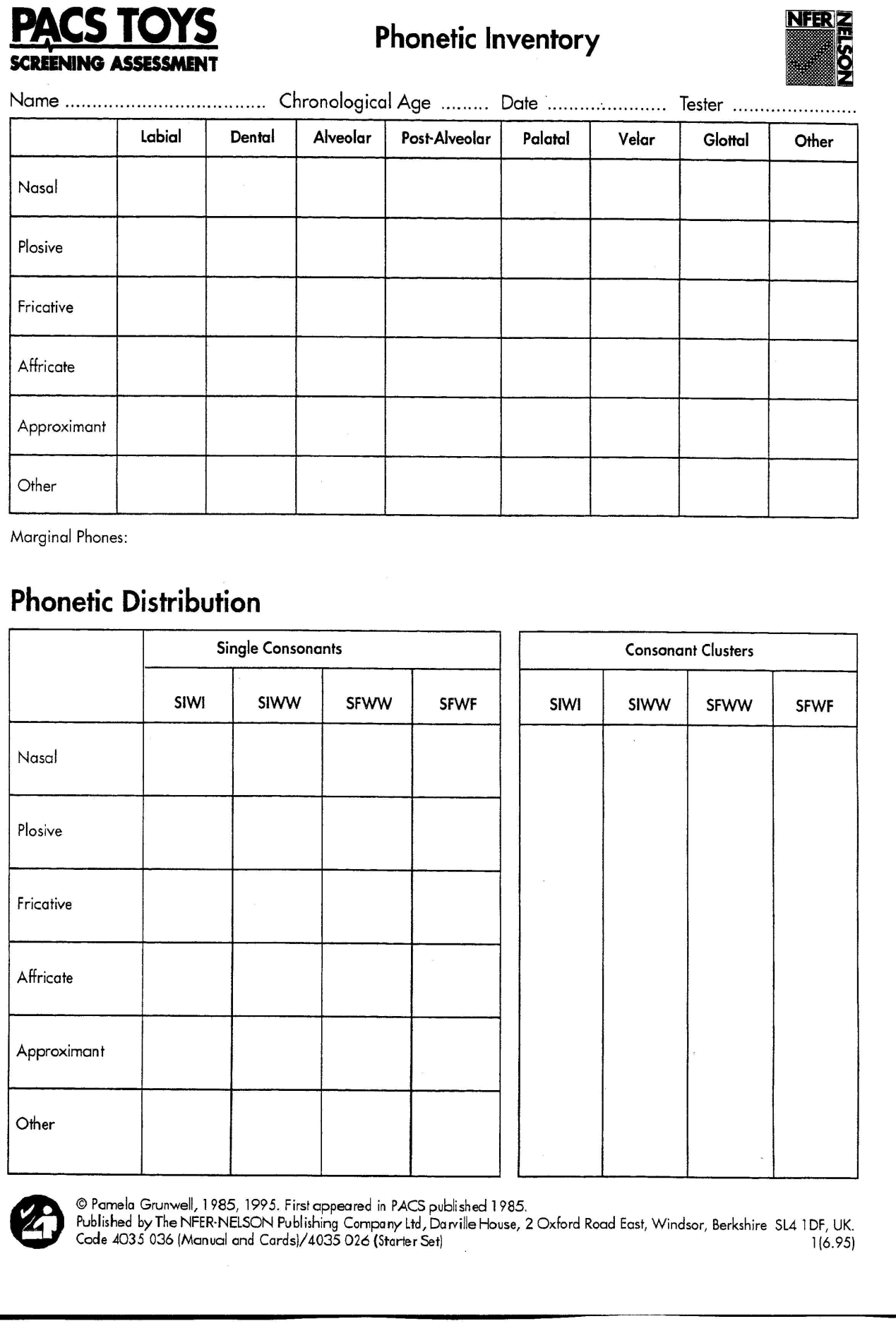
How robust are these results and why

|  |  |  |
| --- | --- | --- |
| Assessment Formal/informal | Age of client at point of testing | Summary of Results/main findings |
|  |  |  |
|  |  |  |

**1.3 Speech and Language Samples**

**Speech samples**

You must include a representative speech sample. You must use appropriate phonetic transcription. Students should complete a PACS profile or similar as and give examples of, and analyse all error patterns etc. The PACS profile is given to remind students that they must give a phonetic inventory and analyse the speech patterns, but students are not required to complete a PACS test in order to use the grid given as this may be used with data from other speech assessments or similar models may be used.

****

**Language sample with summary of findings**

Please note that there will be some clients where a speech and language sample is not necessary to an understanding of their condition e.g. voice clients. However a short description of their communication skills can be made but it may not be necessary to provide considerable detail.

For verbal clients present a representative sample of language (at least 10 utterances, conversation, a sample of words, speech sample, and short interaction). The sample should support and illustrate your clinical thinking. Analyse/comment on the sample using a relevant linguistic framework. You could analyse across the following linguistic levels but this will vary according to your client. Please give both the questions and answers wherever possible and make comment on any relevant aspect of the interaction.

* Semantics (type of vocabulary, number of words, problems)
* Syntax (basic grammatical analysis using LARSP) & morphology (e.g. use of word endings)
* Pragmatics and social use of language

**Non-verbal clients or those with very severe communication difficulties**

For non-verbal clients or those with very severe communication difficulties please give a description of their communication or use a relevant framework such as Means, Reasons, Opportunities (Money and Thurman 1994) or any appropriate model used in service.

**Step 2: Create and present an individual profile (IP)**

Use the format given

i) Identify the pertinent client data from *your workbook* and map it to the following three IP headings:

*A. Impairment, B. Personal Factors & Environmental Factors, C. Impact.*

ii) Label each point on the profile so that you can make reference to them later (e.g. A.1, B.2)

iii) Label potential strengths and weaknesses. Strengths (S) are factors that might enable the client to progress. Weaknesses (W) are factors that might impede progress and may need to be addressed or overcome. Please note that some factors may be both strength and a weakness and this can be marked as (S&W)

iv) Identify missing information. Do this by carefully considering what other information is needed to further your understanding of this client. Explain briefly how this information could be obtained. This will include all missing assessment information with a brief note about how this information might be acquired e.g. which test is required.

|  |
| --- |
| **Impairment (S)** |
| **Impairment (W)** |
| **Personal and Environmental factors (S)** |
| **Personal and Environmental factors (W)** |
| **Impact on activity and participation (S)** |
| **Impact on activity and participation (W)** |
| **Missing information** *( ensure that all opportunities have been taken to collect relevant information)* |

**Step 3: Clinical Hypotheses**

List the hypotheses according to the following headings:

* Nature of impairment
* Severity of impairment
* Impact of impairment on activity and participation

Missing Information

You may not have enough information at this point in time to draw any firm conclusions and this will clearly direct you to collecting further data.

**With some clients there may also need to be a statement(s) about causal and maintaining factors.** This will include medical diagnoses such as cerebral palsy or learning difficulty.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **What are all of the possible hypotheses suggested by the data?** | **What is my evidence for these hypotheses?** | | **What is my evidence against these hypotheses?** | **What information is missing?** |
| **Causal or maintaining factor/s?** | |  |  |  |
|  | |  |  |  |
|  | |  |  |  |
|  | |  |  |  |
| **Nature of Impairment** |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
| **Severity of Impairment** |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
| **Impact of difficulties** |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |

**Step 4: Summary of client data and diagnosis**

Using the information gathered from your workbook introduce your client using format below

|  |  |  |
| --- | --- | --- |
| **Name:** | **Age**: | **Setting**: *Mainstream school* |
| 1. **Describe your client and provide key information about their everyday life.** 2. **Reason for the referral and setting where your client has SLT. Include the amount in time of previous therapy and contact with other services.** 3. **What is your conclusion about the differential diagnosis/description for this client? What are your reasons for these thoughts? What else may you need to investigate/gather information about to inform this?** | | |

**Step 5**

Present a list of all of the references that you have used. Use Harvard referencing conventions