

**CASE STUDY AND VIVA GUIDANCE**

**SALT 3044**

**2017 to 2018**

# INTRODUCTION TO THE PRESENTATION AND VIVA

**University Tutor Assessment report (UTA)**

**Aims of the university assessment**

The University Tutor Assessment report (UTA) makes up 50% of the SALT3044 module mark and combines with the mark generated by the Practice Educator Assessment (PEA) report 50%. The UTA has a greater emphasis on a student’s understanding of theory to practice and evidence based practice. The UTA relates to module learning outcomes 3-13. Students must pass both the PEA and UTA in order to pass the module.

The aims of the university assessment are to provide the student with an opportunity to demonstrate that they can:

* Apply theory to practice.
* Work systematically through the therapeutic process for one client in depth.
* Apply theory to practice, demonstrate clinical reasoning and a developing understanding of evidence based practice when discussing the main client groups and subject areas seen on placement.
* Provide evidence for decision-making which is transparent and explicit at all stages of the clinical process.
* Demonstrate safe levels of insight, reflection and evaluation.

The guidelines for the structure and content of the case study are adapted from clinical reasoning models developed by Whitworth, Franklin & Dodd (2004), Kersner (2001) and Kersner & Parker (2001), Bray Ross and Todd, (2006) and Bunning, (2004). The clinical problem solving model proposed by Whitworth et al (2004) has seven questions which provides a systematic framework for considering the evidence from the data collected about the client in the context of the evidence base including knowledge and research and the constraints governing speech and language therapy services (Dodd et al, 2006). Students are advised to refer to these texts.

**Start Early**

Where possible, start this piece of work as soon as you begin working with the client that you, or your practice educator, have identified as the client for your video recording. This will give you plenty of time to collect the information needed to prepare this case study and presentation.

**Write intervention plans prior to intervention**

Intervention plans are intended to be written prior to intervention and are based on a bringing together, and prioritisation of; client data; theory;evidence base; and client preferences, and are modified to meet the client needs as intervention proceeds. Students must write their plans before seeing their clients and research and modify these continuosly, not write these retrospectively following placement. However we recognise that plans will undergo development following the session as part of the ongoing reflective and evaluative process.

You need to integrate the following principles when writing your case study:

* Use a critical, questioning approach to all aspects of the case study i.e. question what you are doing and why? Is there another approach which would be more effective? Is my approach of benefit to the client? Have I considered the communicative environment?
* Decision-making in the case study should be transparent and clear.
* Use an evidence-based approach to all aspects of your case study and you must provide a theoretical framework to support your decisions
* Consider empowerment of the client and family in the therapy process e.g. How are you involving clients and families in therapy planning and decision making?
* You need to take a broad holistic view of the case and not just report on the impairment
* Consider the members of the MDT team who need to be involved. Who else do I need to liaise with in my management of this client?
* Consider the role of the SLT in the context of the team, the pathways of care available in the given service, and the point at which the client is on that pathway of care.

**Format for the paper sections**

* 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 templates are given at the end of the guide.
* It is important to remember that the client’s confidentiality must be preserved at all times. Students must follow the guidelines on confidentiality and complete the checklist. For the purposes of this study please choose a pseudonym and clearly state this at the beginning of the course work. Failure to comply with the requirements around confidentiality will result in failing this piece of coursework. Students must also refer to the HCPC Code of Ethics for students and RCSLT guidance.

**Notes for students**

1. Students presenting assessment (or clients with whom the student has only had brief contact)

We recognise that students may see clients at any stage in their care pathway and students may present clients seen for initial appointments as well as those attending more regularly. Where the client is early in the assessment process students will be able to set aims for the information that they wish to collect, taking into account a holistic perspective. They must identify the missing information that is needed and plan for how this missing information will be collected. Students must have taken every opportunity available to them to collect the missing information. Students should be able to demonstrate an ability to show sound clinical reasoning in their ability to discuss the next steps for the client in terms of assessment, understanding the assessments results, and thinking forward to planning intervention for this, or similar clients.

2. Working in groups

Student may either:

* Identify a member of the group and relate the group aims and rationale to that particular client making clear how the choice of intervention and group aims will benefit that individual. Students should also be prepared to discuss the management of other group members as this arises in the recording. *(this is the most straightforward option)*
* Or/present the whole group as their ‘client’, outlining their needs as a group and the reasons for their inclusion, and describing the rationales behind the group aims and choice of intervention. Students will need to be prepared to discuss any given client shown on the recording and how their performance, needs or progress in the group relate to the groups aims.

**3. Students on peer placements**

* Students attending placement with a peer should not choose the same client wherever possible. However if there is no alternative due to service requirements, students need to work independently in preparing this study (*although it is recognised that they will work together for the benefit of the client whilst in placement)* and submit original individualised case studies.

Students should contact the Clinical Education Lead to discuss this if this situation arises prior to the recording.

1. **Students presenting training**

Students can state the rationale for the training and the underlying theoretical or evidential basis for the intervention. Often training is designed to impart information around a specific topic and may involve the development of the knowledge and skills base of MDT staff, parents or carers.

* Students can identify a client that they have been working with and relate the benefits of the training to this client, or setting via the training.
* Or students may use the staff group as, ‘the client’ giving a general profile of their training needs.

Please contact the Clinical Education Lead for a discussion about how to prepare for this if training is the preferred option. This option must be discussed prior to the recording to check suitability

# 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. Please see guidance in the placement handbooks.

**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
* USB sticks or other devices with client data must be stored and transported securely. Students must comply with all guidance around handling and transfer of recorded information. Please refer to guidance on Blackboard.
* 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. Video 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.
* Students must take care when using social networking sites, whether these are ‘closed’ groups, only open to other SLT students, or ‘open’. If the information is confidential and is about your service user, patient, client or colleague, or service, you should not put it on a site. This could include information about their personal life, health or circumstances. Specific services must not be named and circumstances described in any way which has the potential to identify patients, clinicians or services. Students must be aware that, even if patient is not identified specifically, there remains a risk of a breach of confidentiality where pieces of information can be added together and patient identification results as the sum of these. Do not use mobile telephones to record clinical information. Students should not usually make personal links with clients, such as adding them as ‘friends’ on Facebook.

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>

Please note:

Final year students are expected to be fully compliant and show understanding of all areas concerned with confidentiality in line with the HCPC SoPs (2014). Breaches of confidentiality will result in a fail in the SALT3044 module and could lead to a ‘Fitness to Practice’ investigation

**De Montfort University**

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

Confidentiality

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 data
* You have stored this information securely, and no unauthorised individual has been allowed to view/listen to this material
* That any client consent form is stored and presented to the university in a **SEALED ENVELOPE**

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*

# PREPARING FOR THE CASE STUDY AND PRESENTATION

**Guidelines for the University Assessment**

**MAKING THE UNIVERSITY VIDEO**

* Each student will be videoed working in an \* intervention session, between weeks 6 to 8 of the placement. This video will then form the basis of their university assessment.
* Students need to video **ONE** \*intervention, approximate length 25 mins depending on the needs of the client***.*** As far as possible the session should be representative of the work that students have been involved in on placement. Students must prepare their session plan **PRIOR** to the carrying out of this session. Please contact the Clinical Education Lead as soon as possible if you are not able to make a video in your setting, or if there are any problems with the recording in terms of length or content. Students must not edit the content of the recording as tutors may choose to watch the entire video for marking or moderation purposes.

\* *an intervention session is understood to be any activity which aims to improve communication/eating and drinking either by work with the client or by work with carers, other professionals or within the environment generally. This can also refer to an assessment session or indirect intervention with carers etc.*

We recognise that there are situations where the student cannot be videoed at all, and, wherever possible, in these circumstances a tutor will arrange to visit and observe the student working with a client live on placement. The case presentation and viva can be carried out successfully using information from a visit and students will not be disadvantaged in this case.

Please see Appendix 1 for the protocol for carrying out the assessment when visited by a tutor.

# THE VIVA PROTOCOL

There are three components to the university assessment

**The Paperwork**

1. This is prepared beforehand and uploaded through Turnitin on the day of the student viva. Please bring a paper copy of the case study to the viva. It is not necessary to provide a paper copy of the presentation.
2. **Please complete Templates 1-5**

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| --- | --- |
| 1.(a) Paperwork | This consists of completion of the Templates 1- 5 given at the end of the guide and provides detailed supporting evidence for the case presentation. It is expected that this will guide student’s thinking for the viva presentation. Students can refer to this information during their presentation rather than repeating information. |
| 1.(b) Confidentiality form | Complete the form in placement, store in sealed envelope and hand in to the SAC for the attention of one of the viva tutors as soon as possible after the recording has been made. Client data must be uploaded and viewed in accordance with the directions given on blackboard. |

**2.** **The Viva Presentation.**

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| --- | --- |
| 2.(a) Viva  The presentation is a timed section and takes 20 minutes (30 in total with the recorded section) This is designed to be realistic in terms of case presentation when in practice. | Students will present the case chosen using power point slides. The laptop computer will be provided by the university. Student will usually present sitting at a table with tutors as this assessment is designed to mimic the type of ‘clinical supervision’ session undertaken by qualified practitioners. However, if students prefer to stand and present their work in a more formal style, then they are free to do so.  Guidelines about what to include are given below. |
| 2.(b) Recorded section | Students will select 2 x 5 minute clips from their original 25 minute session. The original recording must not be edited as tutors may wish to view all of the recording after the viva. Students should note the timings of the clips that they wish to show for ease of access in the viva. Students must provide a rationale to explain why the particular clips have been chosen. |
| **3.Questions**  This is not a timed section but typically takes about 30 minutes | Tutors will question students to explore their understanding of clinical reasoning and theory and evidence base in relation to the client presented and the main client base experienced on placement. |

# PRESENTATION GUIDANCE

The following is guidance on what should be included in the presentation. However the sections do not necessarily correspond to the number of slides needed, as this will be dependent on the individual client. Students may choose in which order to present the information.

Remember, reference can be made to the supporting paperwork if necessary in the viva to avoid repetition.

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| **Data collection and Hypothesis testing** | |
| Students must have an introductory slide including client’s age, reason for engagement with the service, and brief past history of intervention, including progress | |
| What data and assessments have been used and what do the results tell us? | Paper work -Template 1  You will have collected case data and given a summary of the assessments carried out, including a detailed analysis of the client's communication skills and/ or speech and language where appropriate. Identify missing information and the method of proposed data collection. Include data that is relevant to an understanding of the client that you are presenting.  **Presentation**  **Prioritise the data to explain the key results and the profile of the client. What are the individual characteristics of this client suggested by the data? What are the important clues gathered that guide your thinking around hypotheses, clinical description and intervention?** |
| Hypotheses | Paper work – Template 2  Depending on the point in the care pathway of the client that you are seeing you may have a pre-assessment hypothesis, a working hypothesis or a post assessment hypothesis. You must consider the nature, causes, maintaining factors, severity and impact of the communication difficulty. You must give evidence to support your hypotheses. This may be from; the referral data, assessments; progress; observations or the reports of others, and include theory etc.  Students should consider all of the possible hypotheses and present evidence for and against each one.  **Presentation**  **Prioritise the key aspects of the client’s disorder leading to a conclusion/s about the most likely hypotheses and give rationale to support decisions. Make reference to the data that has been handed in. In some case a definitive diagnosis is not helpful or possible and a clinical description identifying the key characteristics and needs of the client is more appropriate. Use theory to support your arguments.** |
| **Intervention** | |
| What are the overall intervention goals?  Ensure a clear relationship between data and intervention decisions in all aspects, from choice of intervention targets to choice of therapy materials | **Presentation**  **The management plan for a client is based on the synthesis of all of the information gathered; assessments, input of client and carers and other professionals as well as the theory and evidence base. Using this information students must provide clear rationale for their decisions and actions.**  **Students should consider the eventual prognosis, care aim (Metcalfe, 2010), or long term aim for their client. Students must set SMART episode of care aims and state an expected time frame for achievement. Students will explain (see below) how the session goals contribute to these long and medium term goals.**  **Students must give clear theoretical rationale and evidence base for aims and they must relate to the client data.** |
| What service delivery model/ care pathway has been chosen? | **Presentation**  **Students should give consideration to the service delivery model. What type of service; the agent of therapy; group or individual; setting; frequency and duration; priority of client; approach to intervention; social or impairment; client or clinician directed; pathway of care etc.** |
| How will you achieve these aims? | Session Plan – Template 3  Paper work  Write a session plan which must include SMART goals based on client data, theoretical rationale or evidence base for approach; methods and materials etc. Students must consider their criteria for success. Clinical reasoning must be clear. Why are you intervening in this way, including with this method and these materials? What do you hope to achieve? How does this move the client towards their eventual care aim?  **Presentation**  **Summarise the aims and key aspects of the session plan (you may make reference to the written plan) and rationales.** |
| Presentation of 2 x 5 minute clips  **Do not edit the recording –** tutors reserve the right to view the entire recording. | **Presentation**  **Students must select 2 x 5 minute clips of their recording (students must retain and hand in the complete unedited version of the session). Students should select clips which demonstrate a key feature of their client’s disorder or performance, or their own skills. Introduce the session briefly and provide a clear rationale for the choice of the clips and what is being demonstrated.**  **In the presentation students may choose at which point to present their clips, but it would be sensible to present this before their evaluation of the session. You can make reference to the written session plan.**  Students who have been unable to make a recording can describe 2 aspects of their session to the tutors from memory. On a visit tutors will watch all of the session as this option that exists for students presenting recorded sessions. Students are advised to take careful notes following their therapy session as they will not have the recording to refer to at a later date. |
| **Evaluation** | |
| **The Evaluation**  Results-Is the chosen management making changes? | **Presentation**   * **Evaluate the effectiveness of your intervention as a whole** * **Explain what happened in the session against the set aims, the implications of the client responses and the resulting actions. Consider the whole intervention plan in the light of what has been learned in the session.**   **Have the results of what happened in this session changed thinking or understanding, and is there anything new that needs to be added or considered, data or theory?**  **What happens next for the client?**  **How will the therapy be generalised outside of the therapy context?**  **See below for further guidance for this section** |

**Evaluation**

(Adapted from Johns, 2000, and Rolfe et al, 2001)

Evaluation involves a reflection on the results of what took place in the session and a critical appraisal of the approach taken both in the session, and with regard to the overall intervention plan.

What has been learned from this experience?

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| --- | --- |
| **What happened?** | Describe the outcomes against the aims  What factors influenced these outcomes;   * Client perspective * Student perspective * Context |
| **So what does this mean?** | What have you learned from what has taken place today?  Do the results move your ‘client’ towards the overall aims of their intervention?  Has this changed your understanding of the client or your thoughts about the decision made so far? |
| **Now what happens?** | What do the outcomes today tell me about the next steps for my client and the intervention?  What needs to change, because of what has been learned, to facilitate further change for the client?  Do I need to do things differently, or access new theory?  How has necessary information been communicated/shared with client/carer/ parent?  How will therapy goals be generalised outside of this situation?  What are the discharge criteria for this client? |

# The Viva Protocol

The case presentation and viva will be assessed by two tutors and will be audio recorded for moderation and equality purposes. The live vivas may be observed by an external examiner, or may be reviewed at a later date via the audio tapes, recorded section, and accompanying paperwork.

The assessment will take approximately one and a half hours.

* Students will present for 30 minutes following the guidance given above including the selected clips taken from an original recording which the student and tutors will watch together. Students may show these clips at their chosen point in the presentation (the 2 different 5 minute clips can be used at different points during the presentation if preferred or may be a complete 10 minute clip)
* Following the student presentation the student will be asked to leave the room whilst the tutors discuss the presentation information, review the supporting paperwork, and set questions. This will take up to 15 minutes.
* Students will return to the viva room and be given the questions in written form and students may ask for qualification of any aspect that is not understood. The student will be given up to 15 minutes to consider the questions. Students may choose not to take the full 15 minutes. No electronic devices or telephones will be allowed, but students may bring supporting information in paper form and refer to this. Failure to comply with these rules will result in a failed module.

**There will be one common question relating to the professional development of the student**

1. **Are you going to be an effective newly qualified speech and language therapist? Outline your strengths and development needs.**

Students should prepare for this by realistically evaluating their strengths and areas of future development as a whole. Students may choose to refer to aspects of the recorded information if relevant to illustrate a particular aspect of their skill set. **(Template 4).**

**Further Questions**

Typically, but not exclusively, further questions will cover;

* Gaps in the data collection
* Interpretation of assessment data
* Hypothesis testing and diagnosis
* Theoretical underpinnings or evidence base for assessment or diagnosis
* Theoretical underpinnings and evidence base for intervention
* Multi-disciplinary working
* Students ability to safely evaluate and reflect for the benefit of the client and future professional practice

All students will be asked the following types of questions

* at least one ‘theory’ based question
* one ‘evidence’ based question.
* one more general question about their learning on placement – related theory or experience. Students must come prepared to discuss other aspects of their learning on placement.

The student will answer the questions as asked and no new topics will be introduced at this point.

Prompting

In order to ensure equity of assessment between students, tutors will be limited to the number of prompts that are used, so students are advised to take every opportunity to share their knowledge. Tutors may use one additional prompt per main question. The degree of prompting is considered when calculating the student grade. Prompts may take the form of the following.

* General prompt (GP) such as, “Can you expand on that?” or “Can you tell us more?”
* Scaffolding prompt (SP) which includes additional information to explore the student knowledge or direct or re-direct the student’s answer.
* 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.

The assessment will then be finished. Students will be given their marks following moderation and consultation with the external examiner. Students will be given feedback via Turnitin (see marking guidance) but are advised to photocopy their paperwork as this will not be returned.

Students must show sound clinical reasoning and demonstrate an ability to relate theory to practice, safe evaluative and reflective skills. The marking criteria are designed to prioritise an understanding of the application of theory to practice. Please refer to the marking criteria outlined on Blackboard.

**Notes about presentation**

Ensure that the content can be presented in 20 minutes. Refer to your paperwork to illustrate points and prevent excessive repetition.

Prepare power point slides to illustrate your points. The presentation will be used with a laptop computer.

A guide is to

* write no more than 5 short lines on a slide
* Use clear script that is well spaced
* Use headings and bullet points and expand on these rather than giving long explanations on the slides.
* Try rehearsing with the slides beforehand
* Choose just two 5 minute clips which will illustrate an aspect of your client, or your performance. Students must be clear about what is illustrated by their chosen examples.
* Try to ‘speak’ rather than read in the presentation
* Refer to the paperwork that you have handed in to avoid repetition

Note: Marks will be given for the ability to succinctly and coherently present the case and explain their clinical thinking as this is a necessary skill for practice rather than ‘presentation skills’ per se.

**Marking**

The profile of each student will be translated into a percentage score (see marking criteria on BB). Examiners will also give feedback to guide further personal and professional development for practice as a newly qualified practitioner.

* The University Tutor Assessment (UTA) report is 50% of the module mark
* The Practice Educator Assessment (PEA) report is 50% of the module mark
* Students must also submit a satisfactory feedback form from their 2nd year peer.

Please see SALT 3044 Practice Educator/ Student Practice Guide and BB for detailed information about assessment criteria.

# TEMPLATES

**Template A: Client data collection**

**Please note that the ability to collect and present relevant data is a necessary clinical skill. Students must make a judgement about which is necessary and relevant to illustrate their understanding of their client’s communication difficulties and intervention plan.**

This is where you collect and record a wide range of relevent client data (anonymised). This section is similar to a client case history and ideally you will be writing it as soon as you meet your client. By the time you come to write the full intervention plan you will be able to refer to this to find evidence which will support your clinical decision making for this client.

**Client Data**

In this sectionyou may use bullet points. State where the information comes from and the age of the client at that time. Note any gaps that you think are important by writing ‘not known’.

* 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 but may vary:

* 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 are 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. **Assessment detail**

Students are advised to consider a client’s communication difficulties in the

context of their general, social and emotional development and well- being.

What is your evidence and how can this be tested or the information obtained?

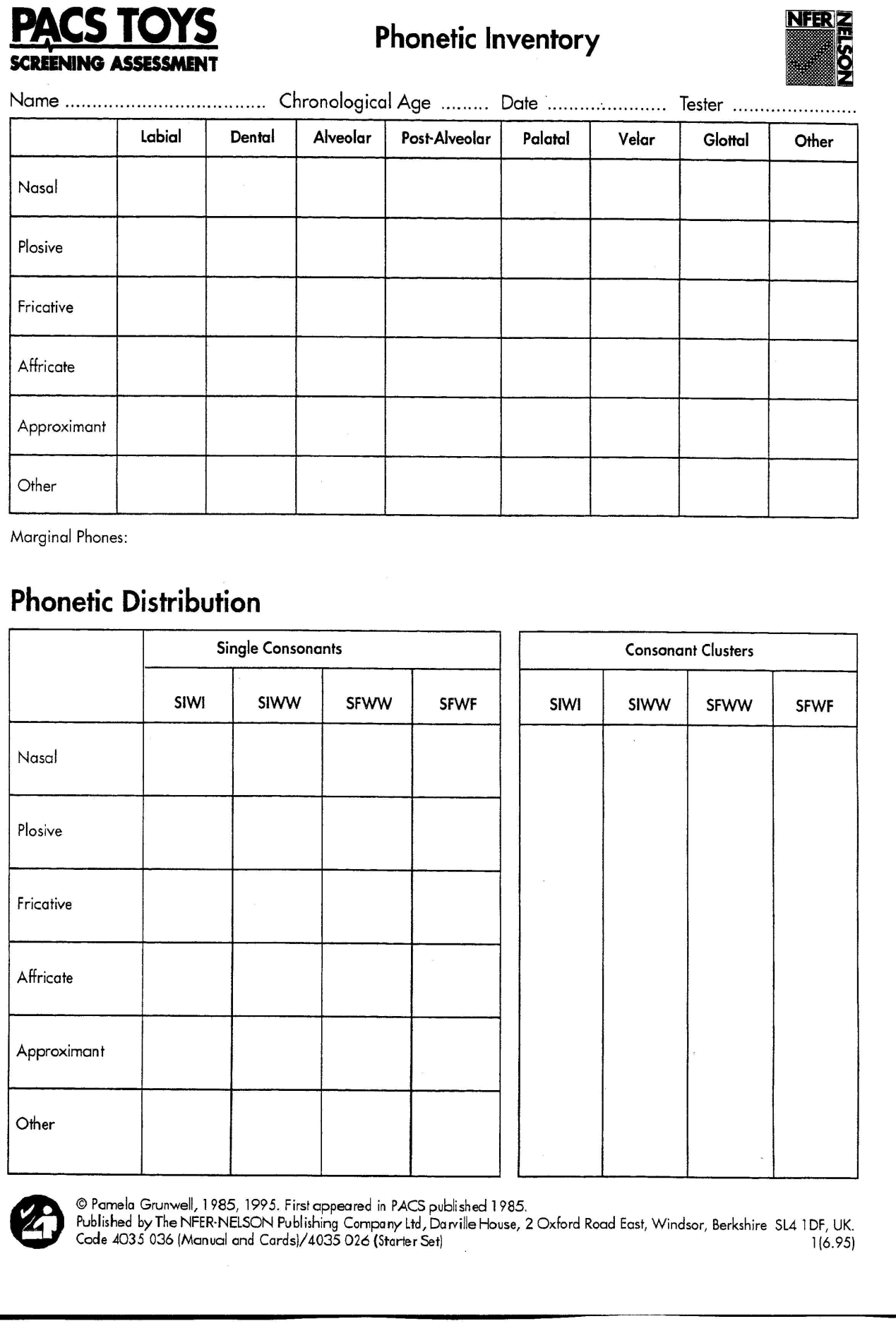
|  |  |  |
| --- | --- | --- |
| Assessment  Formal/informal  What does your assessment test? | Age of client at point of testing | Summary of Results/main findings |
|  |  |  |

1**.3 Speech, language and communication samples**

**Speech samples**

You must include a representative speech sample where appropriate. You must use appropriate phonetic transcription. Complete the PACS profile or similar and give examples of, and analyse all error patterns etc. (it is not necessary to complete a PACs assessment). This is given only as a reminder of the necessity to analyse all aspects of speech for relevant clients.

Please refer to different subject areas for the most appropriate framework for presenting data.



**Language Sample**

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. You may be able to use the transcript from your recorded session.

For verbal clients present a representative sample of language (at least 10 utterances). The sample must illustrate your clinical thinking or stated opinion about the client. For example if a child has age appropriate language, or a client has difficulty with word finding in conversation, then the sample given must illustrate this. Wherever possible the sample must include the interaction (that is both the question and the answer)

**Language sample.** Students must analyse/comment on the sample using a relevant linguistic framework such as LARSP. You could analyse across the following linguistic levels but this will vary according to your client’s problems

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

Depending on the presentation of the client more information may be relevant in one area than another

**Non -verbal clients/severe communication difficulties**

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

**1.4 Assessment Summary**

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| What specifically have you learned about your client from all of the data, including the case data that will help you to understand their difficulties, and what key factors about their impairment, life and wishes, must be considered for their future management?  What information is missing? What is not yet known?  This section can be expressed as a list of hypotheses or Individual Profile if preferred.  What are the key difficulties to address in any intervention? |
|  |

**Template: 2**

**Hypothesis testing**

**Generate Clinical Hypotheses leading to clinical description or diagnosis of communication difficulty (SLT’s are concerned with clinical description or diagnosis of communication problems)**

Generating clinical hypotheses is the first step in providing a clinical description or diagnosis. We use diagnostic skills in order to find out:

* Whether a communication disorder is evident
* What other factors need to be considered
* How to describe the disorder
* Whether the client should be evaluated further
* What kind of disorder is present, as compared to a variety of other possible disorders, when the signs and symptoms and assessment evidence are analysed (this is differentiating between the possible options hence - differential diagnosis; differentiating one hypothesis from another)
* It can also help you to identify elements of the client’s difficulty for further assessment or intervention
* The key features that need to be considered when planning intervention

**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.

The first step is to generate a series of **all** the possible clinical hypotheses about the client’s communication difficulty **suggested by the data** on the given client.

Hypotheses are statements that can be tested, and will in time, be accepted or rejected, so that you can arrive at the most likely or sensible clinical description/diagnosis for your client at any given point in time.

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

**Severity rating**

A severity rating may relate to the score on a formal assessment, the client’s level of concern, the attitude of others, the prioritisation system of the service involved, the number of co-existing conditions etc. When considering the severity rating it is necessary to take into account the client from a holistic perspective. Students should also refer to their individual lectures about different client groups when considering severity ratings.

**Missing information.**

You may, or may not, have enough information at this point in time to draw any firm conclusions depending on the point of care. Please state what is missing and how this can be collected

**Statement(s) about causal and maintaining factors.** This will include medical diagnoses and diagnosis made by professionals other than SLTs such as cerebral palsy, learning difficulty, TBI, CVA, hearing impairment, environmental factors etc.

|  |  |  |  |
| --- | --- | --- | --- |
| **What are all the possible**  **hypotheses suggested by the data?** | **What is the evidence for?** (cite client data and theory) | **What is the evidence against?**  (cite client data and theory) | **What information is missing?** |
| **Causal/maintaining factors** |  |  |  |
|  |  |  |  |
| **Nature of Impairment**  *These may relate to differential diagnosis or descriptions of the nature of the communication disorder* |  |  |  |
|  |  |  |  |
| **Severity of Impairment** |  |  |  |
|  |  |  |  |
| **Impact of difficulties** |  |  |  |
|  |  |  |  |

**Template 3: The Intervention Plan**

Present the information using the table format below.

|  |  |
| --- | --- |
| Student:  Setting:  Date:  Therapy participants: | Client: ( pseudonym)  Age:  Length of session:  Session Number / |
| LONG TERM AIM (give time frame) | Rationale |
| SHORT TERM AIMS (give time frame) | Rationale |
| **SMART SESSION AIM** (number of aims will vary between clients)  1.  2. | |
| **RATIONALE FOR SELECTION OF AIM** *( students must justify all decisions based on client data; including progress, theory, client preferences and evidence base- reference may be made to overall aims identified.*  **1.**  **2.** | |
| **ACTIVITIES/TASKS** *(include procedure, instructions, opening and closing, feedback techniques, links to generalisation, and sharing information and advice) and material*  1.  2 | |
| PLANNED MODIFICATIONS **(increase/ decrease in difficulty)**  **1.**  **2.** | |
| **SMART SESSION AIM**  1.  2. | |
| **RATIONALE FOR SELECTION OF AIM**  **1.**  **2.** | |
| **ACTIVITIES/TASKS** *(include procedure, instructions, opening and closing, feedback techniques, links to generalisation, and sharing information and advice) and material*  **1.**  **2**. | |
| PLANNED MODIFICATIONS **(increase/ decrease in difficulty)**  **1.**  **2.** | |

|  |
| --- |
| **Consider the SLT specific skills needed to meet the aims outlined above**  *Including:*  *Any supporting theory*  *Establishing and maintaining a therapeutic relationship with the client*  *Support techniques such as feedback/ rewards during a task, adding or removing cues as necessary during a task, methods for motivation, maintaining interest,*  *Keeping client informed throughout the session and feedback at the end of a task/session*  *Using equipment and instrumentation.*  *Organising materials during the session,*  *Time keeping*  *Adapting communication style to meet the needs of the client, promoting their well- being and emotional and psychological needs*  *Maintaining interest and attention* |

**Template: 4** **REFLECTION FORM**

*This is to guide students in thinking about the ‘set’ viva question*

**Date:**

*Two key strengths as an NQP*

*1.*

2.

3.

*Two development points as an NQP:*

*1.*

*2.*

**Template: 5**

References

You must give a comprehensive reference list

Make sure you use current literature and that your reading has both depth and breadth. Research any evidence base around the intervention for your client, alternative approaches, outcome measures etc.

References used for preparing this guidance and useful reading for preparing a case study

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# APPENDIX 1

# Protocol for visits in place of recorded sessions

It is recognised that visits are usually required where students are unable to obtain consent or where a service does not allow for recording.

Students should prepare an outline plan of the activity/ session that they are to undertake with session aims, method and rationale (please see template in Placement Log). If this is a peered placement (such as a jointly run group) then students may work together on the initial session plan, however the elaborated plan handed in at the viva and their evaluation of the session must be prepared independently of each other.

Please note if the client to be seen is an initial contact then the student will still need to be able to specify their; aims for the assessment; proposed method; range of potential actions based on the referral information; even if they are not able to provide a detailed plan.

* Wherever possible the student should e-mail the tutor the outline plan prior to the visit or, where the client is not identified until the day, hand the tutor an outline plan of what is intended on the day. The student and university tutor (and Practice Educator (PE), if appropriate) should have the opportunity for a short pre-session discussion to explain any changes of circumstance on the day and procedure of the session etc. The timing of this is left to the discretion of the placement.
* The session is carried out – the university tutor observes the whole session (there may be exceptions to this depending on the client needs) and makes and records notes about the student performance.
* Student and tutor (and PE, if appropriate) tutor have the opportunity for a short discussion to discuss any circumstances that have arisen on the day which may not be covered later by the students evaluation of the session.
* We would ask Practice Educators, wherever possible, to allow students to have an opportunity to record any observations and notes immediately following the observed session in order to capture their evaluation and reflections of the session whilst this is fresh in their mind.
* Following the observed session students then prepare the elaborated intervention plan based on the guidance in the Case Study handbook. This then handed in to the tutor who has carried out the observation at the university in the usual way. It is advised that students prepare this as fully as possible whilst they are on placement to allow for accurate recall of their client.

As students do not have the advantage of the recorded session to remind them of their session, the hand in of the full plan and the timing of the viva can be negotiated between student and observing tutor ( depending on staff and student availability). However if students prefer they may adhere to the same hand- in and viva dates as the rest of the year group.