



Royal College of Speech and Language Therapists

Speech and Language Therapy Stroke Audit: Guidance Notes for the longer tool

This audit has been produced by representatives of the Royal College of Speech & Language Therapists (RCSLT), having been developed and approved by the Intercollegiate Working Party for Stroke, Royal College of Physicians (RCP). The National Sentinel Stroke Audit (NSSA) provides an audit of stroke services and case profiles. It is intended that this profession specific audit can be used alongside the NSSA to provide a more detailed description of the Speech & Language Therapy contribution to stroke care. It is based on the evidence demonstrated through the National Clinical Guidelines for Stroke, but also supported by work related to Speech & Language Therapy care more generally. The audit relates to speech & language therapy care delivered in secondary care settings, including both acute and rehabilitation services.

Profession specific stroke audits are also available for occupational therapy, physiotherapy, dietetics and nursing.

Aims of the audit

The aims of the Speech & Language Therapy stroke audit are:

- to delineate the organisational structures and processes related to Speech & Language Therapy care of people within Stroke Services in the UK;
- to describe the pattern of Speech & Language Therapy care activities and interventions delivered to individual stroke patients within Stroke Services in the UK;

Guidance Notes on the use of this audit tool

The audit of service organisation (questions 1–16) will require only one proforma per department. Please do not leave any sections blank. Where all relevant data sources are missing, the response should be 'No but...' (data missing/unobtainable). However, care should be taken that unobtainable data does not mask real failures to meet standards. Responses may be used internally to form the basis of a report describing Speech & Language Therapy services; where appropriate this will also provide detail of compliance with recommendations from the National Clinical Guidelines for Stroke.

The audit of the processes of care (questions 17-48) will require a separate proforma to audit the records of each case. The audit can be completed using an excel file or a word document.

PART 1: SLT SERVICE ORGANISATIONAL AUDIT.

Section 1: SLT Staffing.

Standard.	Rationale.	Question(s).
Care for people with stroke should be provided by a formally organised Stroke specialist MDT team with specific speciality in stroke.	The evidence for optimal outcomes for stroke is co-ordinated MDT care with speciality in stroke. RCP National clinical guidelines for stroke 2 nd edition (June 2004)	1a. Does the service have a stroke specialist SLT therapist post? <i>Answer 'no but' if the post is vacant at the time of audit.</i> 1b. "...SLT providing care ...for more than 50% of their time" <i>Answer 'no but' if the service has speciality in neurological rehabilitation of which Stroke is included, or post is vacant at the time of audit</i>
There is a service level agreement (SLA), contract or equivalent with the unit/trust specifying access, location, activity, resources, response times, standards, monitoring and evaluation.	RCSLT specifies that there is a need for services to plan service provision with a continuous workforce development strategy to enable a responsive and appropriate level of service to meet the needs of	2. Does the SLT service (at the time of audit) have any vacancies in the staff who deliver care to Stroke patients? <i>Answer 'no but' if the service has vacancies which are currently filled by temporary staffing.(Maternity or long-term</i>

patients of the service.

sick leave would answer 'yes' if no extra cover provided.)

Section 2: SLT participation in stroke-related CPD activities

Standard.	Rationale.	Question(s).
Recommendations for stroke are based on best available evidence. It is the responsibility for health services to support high quality research. RCP National clinical guidelines for stroke 2 nd edition (June 2004)	<p>"There are many areas of stroke medicine where the evidence base is weak".</p> <p>"Involvement in research not only advances scientific knowledge but also helps improve the quality of care, levels of staff satisfaction and retention". RCP National clinical guidelines for stroke 2nd edition (June 2004)</p>	<p>3. Do SLT's within your stroke services attend stroke-related courses?</p> <p>4. Do SLT's within your stroke services participate in stroke-relevant research?</p> <p>5. Do SLT's within your stroke services lead on stroke-relevant research?</p> <p><i>Answer 'no but' if there is a nominated post but the post-holder is on maternity or sick leave or post is vacant at the time of this audit.</i></p>

Section 3: Overall service organisation.

Standard.	Rationale.	Question(s).
Care for people with stroke should include the provision of intensive intervention by a formally organised Stroke specialist MDT team with specific speciality in stroke.	<p>The evidence for optimal outcomes for stroke is co-ordinated intensive MDT care with speciality in stroke.</p> <p>Evidence also suggests that services offering longer-term rehabilitation & follow-up have better long term patient outcomes. RCP National clinical guidelines for stroke 2nd edition (June 2004)</p>	<p>6. Does your service provide an inpatient stroke service inclusive of acute & inpatient rehabilitative care?</p> <p>7. Does your service provide a clinic/hospital-based outpatient service?</p> <p>8. Does your service provide a community / domiciliary service?</p> <p>9. Is your service included in an early supported discharge scheme?</p> <p><i>Answer 'no but' where a service has been set up but you are currently unable to provide it owing to resource issues.</i></p> <p><i>Please estimate the number of sessions available for stroke for each of the above as relevant. Please estimate for Stroke alone rather than for the broader neurology speciality which would include stroke.</i></p>
Procedures for responding to referrals will follow local policy appropriate to the nature of the specific client group. Any prioritisation of accepted referrals should be determined in a systematic and equitable manner. RCSLT CQ3 (2006)	Following referral, a SLT will respond within 2-10 working days of receipt of referral for clients at high risk and within 13 weeks of receipt of referral for clients at lower risk. RCSLT CQ3 (2006)	<p>10. Is there a locally agreed prioritisation system based on clinical need for inpatients?</p> <p><i>Answer 'no but' if the service is not responsible for the provision of inpatient acute care or rehabilitation.</i></p> <p>11. Is there a locally agreed prioritisation system based on clinical need for community and outpatients?</p> <p><i>Answer 'no but' if the service is not responsible for the provision of outpatient or community care.</i></p>
The service should follow a recognised care pathway for stroke.	Care pathways help to reduce unnecessary variations in individual care and outcomes and support development of care partnerships. RCSLT CQ3 (2006)	<p>12. Are SLT's involved in developing local care pathways for stroke?</p> <p><i>Answer 'no but' if there are plans in place to develop a local care pathway for stroke but have not yet started.</i></p>

Section 4: Screening.

Standard.	Rationale.	Question(s).
Care is provided by a formally organised Stroke specialist MDT team with specific speciality in stroke.	The evidence for optimal outcomes for stroke is co-ordinated MDT care with speciality in stroke. RCP National clinical guidelines for stroke 2 nd edition (June 2004)	13. Is there an agreed protocol for screening of a communication problem by another professional other than an SLT using an agreed tool? <i>Answer 'no but' if the tool was developed independent of SLT involvement or if the tool is being trialled on a pilot basis.</i> 14. Is there an agreed protocol for screening of a swallowing problem by another professional other than an SLT using an agreed tool? <i>Answer 'no but' if the tool was developed independent of SLT involvement or if the tool is being trialled on a pilot basis.</i>

Section 5: Assessment

Standard.	Rationale.	Question(s).
Clients should have equal access to a timely, responsive and quality instrumental evaluation of swallowing. RCLST Policy statement (2007)	FEES is a recognised, valid tool for the assessment and management of swallowing disorders. RCLST Policy Statement (2005) Videofluroscopy is a recognised tool for the assessment of swallowing disorders and SLTs have had a long association in the use of this procedure. RCLST Policy statement (2007)	15a Does your service have access to FEES? <i>Answer 'no but' if the service is available for some patients but not offered to all appropriate patients (i.e. those who are not physically able to access the service because the service not on site)</i> 15b If yes, is the current waiting time for a FEES assessment 48 hours – 5 days? <i>Answer 'no but' if service not available.</i> <i>Please answer this question if you have answered 'no but' to question 15a</i> 16a Does your service have access to videofluroscopy (VFS)? <i>Answer 'no but' if the service is available for some patients but not offered to all appropriate patients (i.e. those who are not physically able to access the service because the service not on site or appropriate seating not available)</i> 16b If yes, is the current waiting time for a VFS assessment 48 hours – 5 days? <i>Answer 'no but' if service not available.</i> <i>Please answer this question if you have answered 'no but' to question 16a</i>

PART 2: DELIVERY OF CARE AUDIT

Section 1: Referral and assessment

Standard.	Rationale.	Question(s).
<p>Standard 1: Procedures for responding to referrals will follow local policy appropriate to the client group. Recommended response times following referral are: Inpatient with a high risk swallowing problem will be seen within 2 working days of receipt of referral Inpatient with newly acquired communication problem will be seen within 10 days of receipt of referral. Outpatient or community/domiciliary client will be seen within 13 weeks of receipt of referral. RCSLT Communicating Quality 3 (2006).</p>	<p>Clients should be seen soon after referral to avoid unnecessary medical or psychosocial harm.</p>	<p>17. Is the date of referral documented? 18. Does the referral response time fall within agreed timescales? <i>Answer 'no but' if the client was unavailable, unconscious, too unwell to be seen, or refused appointment.</i></p>
<p>Standard 2: There will be a full assessment of each person's communication and swallowing problem carried out as appropriate to the stage of recovery and environment, which is communicated to the client, carer and MDT. RCSLT CQ3 (2006)</p>	<p>Clients may initially be screened by another appropriately trained professional as part of the locally agreed care pathway. There should be written evidence of the use of the screening tool and clear guidelines for referral on to SLT as part of this care pathway.</p> <p>Results of investigations, assessment findings and planned management for communication and/or swallowing problems should be discussed with the client and carer in accordance with a patient-centred approach and reported in writing to the team. Medical records are kept up to date, as appropriate.</p>	<p>19. Is there written evidence for screening of a communication problem by another professional other than an SLT using an agreed tool? <i>Answer 'no but' if seen by the SLT only, there is no agreed tool or client unconscious or refuses/is unable to participate in assessment.</i></p> <p>20. Is there written entry of the client's pre-morbid communication function? <i>Answer 'no but' if the client has no carer/friends to provide this information</i></p> <p>21. Is there written evidence of formal and informal assessments of the client's communication skills by a SLT? <i>Answer 'no but' if client unconscious or refuses to participate in assessment. In case of acute inpatients formal assessment could include subsections of an oromotor assessment or subsections of a functional communication assessment. However answer 'no but' if patient too acutely unwell to undergo formal assessment.</i></p> <p>22. Is there written evidence for screening of a swallowing problem by another professional other than an SLT using the agreed tool? <i>Answer 'no but' if seen by the SLT only, there is no agreed tool or client unconscious or refuses/is unable to participate in assessment.</i></p> <p>23. Is there written evidence of appropriate referral on to SLT?</p>

		<p>24. Is there written entry of the client's pre-morbid swallowing function? <i>Answer 'no but' if the client has no carer/friends to provide this information</i></p> <p>25. Is there written evidence of a comprehensive assessment of the client's swallowing abilities by a SLT? <i>Answer 'no but' if client unconscious, too unwell or refuses to participate in assessment.</i></p> <p>26. Is there written evidence of a summary of the assessment results? <i>Answer 'no but' if unable to carry out assessment owing to client too unwell, or refused, or client died before assessment appropriate</i></p> <p>27. Is there written evidence that assessment results were communicated by the SLT to the client and carers? <i>Answer 'no but' if client has severe impairment and lacks capacity, refused assessment, has no carer involved, client died before assessment appropriate</i></p> <p>28. Is there written evidence that assessment results were communicated to the MDT? <i>Answer 'no but' if client refused assessment or died before assessment appropriate</i></p>
--	--	---

Section 2: Intervention

Standard.	Rationale.	Question(s).
<p>Standard 3: A SLT management plan will be agreed and discussed with the client and will implement an appropriate, timely and integrated approach involving them, their family and other professionals. RCSLT CQ3 (2006)</p>	<p>SLT intervention should take a partnership approach in accordance with client-centred care.</p> <p>Management of the client should involve all relevant people to enable a holistic approach.</p>	<p>29. Is there a written SLT management plan specifying type of intervention <i>Answer 'no but' if intervention not indicated or refused.</i></p> <p>30. Is there a written SLT management plan specifying goals of intervention? <i>Answer 'no but' if intervention not indicated or refused.</i></p> <p>31. Is there a written SLT management plan specifying review arrangements? <i>Answer 'no but' if review not appropriate or refused.</i></p> <p>32. Is there written evidence that the management plan has been discussed and agreed with the client? <i>Answer 'no but' if client unconscious or unable to participate owing to very</i></p>

		<p><i>severe comprehension or cognitive problems or intervention not needed or refused.</i></p> <p>33. Is there written evidence that the management plan has been discussed with the carer(s)? <i>Answer 'no but' if the client does not have any carers involved or client refused consent for therapist to discuss with carer(s).</i></p> <p>34. Is there written evidence of SLT liaison with MDT eg attendance at MDT meetings, or similar forum, regular telephone contact? <i>Answer 'no but' if no other member of MDT involved or client refused consent to discuss with MDT.</i></p>
--	--	--

Section 3: Evaluation and Outcome

Standard.	Rationale.	Question(s).
<p>Standard 4: The SLT will evaluate the effects of intervention in consultation with the client, carers and the MDT. RCSLT CQ3 (2006)</p>	<p>Evaluation of SLT input and the client's progress will take place at regular stages, at least after a block of intervention (episode of care) or at the end of a SLT programme.</p> <p>Evaluation measures may include published assessments, informal assessments, rating scales, video/audio data etc.</p> <p>Evaluation will be communicated to the referring agent in writing, and to others as appropriate, consistent with local policy and the management of the individual client.</p> <p>Information will be transferred to the appropriate professional for continuity of care where intervention is expected to continue.</p>	<p>35. Is evaluation documented at the end of the previously defined treatment programme or block of treatment? <i>Answer 'no but' if assessment only with no need for follow-up.</i></p> <p>36. Is there written evidence of the use of an appropriate outcome tool measure when evaluating communication intervention? <i>Answer 'no but' if assessment only with no need for follow-up., or not referred for communication problem.</i></p> <p>37. Is there written evidence of the use of an appropriate outcome tool measure when evaluating dysphagia intervention? <i>Answer 'no but' if assessment only with no need for follow-up, or not referred for swallowing problem</i></p> <p>38. Are results, conclusions and recommendations clearly documented, consistent with local policy, eg SLT notes, joint records?</p> <p>39. Is there written evidence of discussion of evaluation/outcome with the client? <i>Answer 'no but' if client unconscious, unable to participate owing to very severe comprehension or cognitive problems , or no intervention given.</i></p> <p>40. Is there written evidence of discussion of evaluation/outcome with the carer?</p>

		<p><i>Answer 'no but' if the client does not have any carers involved, client refused consent to discuss with carer(s), or no intervention given.</i></p> <p>41. Is there written evidence of written and/or telephone transfer of information to ensure ongoing care for the client (eg to GP, other SLT, intermediate care team)? <i>Answer 'no but' if client denied access of report to other professionals or ongoing care not needed.</i></p>
--	--	---

Section 4: Discharge

Standard.	Rationale.	Question(s).
<p>Standard 5: Discharge from SLT services will be planned and organised in consultation with the client and carer. RCSLT CQ3 (2006)</p>	<p>Clients and carers should be involved and prepared for discharge, the criteria for which should be discussed at the earliest appropriate stage in the intervention process. All clients and carers should be given information about voluntary and statutory support agencies as part of intervention and they should be encouraged to make contact before discharge.</p> <p>A written report summarising intervention, outcomes, reason for discharge and discharge arrangements will be provided to the client and any other appropriate health and/or social care professional.</p>	<p>42. Is there written evidence that the criteria for discharge was discussed with the client prior to discharge? <i>Answer 'no but' if client unconscious, unable to participate owing to very severe comprehension or cognitive problems, died before discharge, or has been transferred on.</i></p> <p>43. Is there written evidence that the criteria for discharge was discussed with the carer prior to discharge? <i>Answer 'no but' if the client does not have any carers involved, client refused consent for carers to be informed, client died before discharge, or has been transferred on.</i></p> <p>44. Is the response of the client/ carer to discharge documented? <i>Answer 'no but' if client unconscious, unable to participate owing to very severe comprehension or cognitive problems, does not have any carers involved, died before discharge, or has been transferred on.</i></p> <p>45. Is there written evidence of the provision of information about voluntary and statutory support agencies? <i>Answer 'no but' if there are no appropriate voluntary agencies for the client's needs.</i></p> <p>46. Is there written evidence that the client/carers was given a named SLT contact on discharge? <i>Answer 'no but' if not discharged.</i></p> <p>47. Was a timely written discharge report provided to the client? <i>Answer 'no but' if client unconscious, died before discharge, if written</i></p>



Royal College
of Physicians
Setting higher medical standards

		<p><i>material is inappropriate owing to very severe comprehension or cognitive problems, if client an inpatient or been transferred on.</i></p> <p>48. Was a timely written discharge report provided to other professionals as appropriate? <i>Answer 'no but' if client denied access of report to other professionals, died before discharge, or been transferred on.</i></p>
--	--	---

References:

Royal College of Physicians National Clinical Guidelines for Stroke 2nd edition (June 2004)

Royal College of Speech and Language Therapists Communicating Quality 3 (2006).

Royal College of Speech and Language Therapists Policy statement 2007: Videofluoroscopic Evaluation of Oropharyngeal Swallowing Disorders (VFS) in Adults: The role of speech and language therapists

Royal College of Speech and Language Therapists Policy statement 2005: Fiberoptic Endoscopic Evaluation of Swallowing (FEES). The role of speech and language therapy