



Royal College of Speech and Language Therapists

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

PART 2: Clinical Case Note 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>1. Does the referral response time fall within RCSLT agreed timescales?</p> <p><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>A comprehensive assessment should be undertaken for communication and/or swallowing problems for the purposes of diagnosis and management. Results of investigations, and assessment findings should be discussed with the client in accordance with a client-centred approach.</p>	<p>2. Is there evidence of assessment of: a) pre-morbid communication?</p> <p><i>Answer 'no but' if there is no evidence of a communication problem, or if the client was unconscious, too unwell to be seen, refused to participate, or no carer to contact</i></p> <p>b) Comprehension? c) Oromotor skill?</p> <p><i>Answer 'no but' if there is no evidence of a communication problem, or if the client was unconscious, too unwell to be seen, or refused to participate.</i></p> <p>3. Is evidence of assessment of: a) pre-morbid swallowing ability?</p> <p><i>Answer 'no but' if there is no evidence of a swallowing problem, or</i></p>

		<p><i>if the client was unconscious, too unwell to be seen, refused to participate or no carer to contact.</i></p> <p>b) oral function? c) pharyngeal function?</p> <p><i>Answer 'no but' if there was no evidence of a swallowing problem, or if the client was unconscious, too unwell to be seen, or refused to participate.</i></p> <p>4. Is there evidence that assessment results were communicated by the SLT to the client?</p> <p><i>Answer 'no but' if assessment could not be completed because client was unconscious, too unwell, refused to participate, or had severe communication/cognitive impairment and lacked capacity.</i></p>
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Section 2: Goal-setting and 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 be appropriate to the type of problem being addressed and should be goal-oriented. The SLT should take a partnership approach in accordance with client-centred care. Management plans should be discussed with the client and should involve all relevant people to enable a holistic approach.</p>	<p>5. Is there a evidence of a SLT management plan specifying type of intervention</p> <p><i>Answer 'no but' if intervention not indicated or refused.</i></p> <p>6. Is there evidence of a SLT management plan specifying goals of intervention?</p> <p><i>Answer 'no but' if intervention not indicated or refused.</i></p> <p>7. Is there evidence that the management plan has been agreed with the client?</p> <p><i>Answer 'no but' if intervention not indicated or refused, client unconscious, too unwell, or unable to participate owing to very severe communication/cognitive problems.</i></p>

Section 3: Team working

Standard.	Rationale.	Question(s).
Standard 5: Intervention should be provided as part of a multi-agency team. RCSLT CQ3 (2006)	It is recognised that working with the client in coordination with other professionals enables a holistic and cohesive approach to treatment.	8. Is there 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>

Section 4: Evaluation/Transfer of care/ Discharge

Standard.	Rationale.	Question(s).
Standard 4: The SLT will evaluate the effects of intervention in consultation with the client, carers and the MDT. RCSLT CQ3 (2006)	<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. Evaluation of treatment will be discussed with the client and carers.</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>	9. Is there evidence of discussion of outcome with the client? <i>Answer 'no but' if client, unable to participate owing to very severe comprehension/ cognitive problems, or no intervention given.</i> 10. Is there evidence of discussion of outcome with the carer? <i>Answer 'no but' if the client does not have any carers involved, client refused consent to discuss with carer(s), no need to discuss with a carer, or no intervention given.</i> 11. Is there evidence of discussion of outcome with other professionals? (e.g. to GP, other SLT, intermediate care team)? <i>Answer 'no but' if client refused discussion with other professionals or ongoing care not needed.</i>
Standard 5: Discharge from SLT services will be planned and organised in consultation with the client and carer. RCSLT CQ3 (2006)	<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. A named contact should be provided on discharge to enable re-referral if necessary.</p> <p>A written report summarising intervention, outcomes, reason for discharge and discharge arrangements will be provided to the client/carer.</p>	12. Is there evidence that the client/carer was given a named SLT contact on discharge? <i>Answer 'no but' if not discharged.</i> 13. Is there evidence that a discharge report was given to the client/carer on discharge? <i>Answer 'no but' if client not discharged, died before discharge, or if client an inpatient or been transferred on within the service.</i>



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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