



Royal College of Speech and Language Therapists SLT Profession Specific Audit of Stroke Care - shorter tool

Clinical Casenote Audit – Part 2.

Clinical site code..... Patient ID.....

Age (in years)..... Date of admission to hospital.....

Date first seen by your discipline.....

	Yes	No	No But
Specify the service location of the patient at time of audit (Tick only one)			
Inpatient			
Outpatient			
Domiciliary			
Referral and assessment			
<p>1. Does the referral response time fall within RCSLT agreed timescales? ie within 2 working days if extremely high risk of choking, within 10 working days if high risk of dysphagia or psychosocial impact and within 13 weeks for all others.</p> <p><i>Answer 'no but' if the client was unavailable, unconscious, too unwell to be seen, or refused appointment.</i></p>			
<p>2. Is there evidence of assessment of:</p> <p>a) pre-morbid communication function?</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?</p> <p><i>Answer 'no but' if there is no evidence of a communication problem, or if the client</i></p>			

<i>was unconscious, too unwell to be seen, refused to participate.</i>			
c) oromotor skills? <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.</i>			
3. Is there evidence of assessment of: a) pre-morbid swallowing ability? <i>Answer 'no but' if there is no evidence of a swallowing problem, or if the client was unconscious, too unwell to be seen, refused to participate, or no carer to contact.</i>			
b) oral function? <i>Answer 'no but' if there is no evidence of a swallowing problem, or if the client was unconscious, too unwell to be seen, or refused to participate.</i>			
c) Pharyngeal function? <i>Answer 'no but' if there is no evidence of a swallowing problem, or if the client was unconscious, too unwell to be seen, or refused to participate.</i>			
4. Is there evidence that assessment results were communicated by the SLT to the client? <i>Answer 'no but' if assessment could not be completed because client was unconscious, too unwell, refused to participate, or had very severe communication/cognitive impairment and lacked capacity.</i>			

Goal setting & Intervention	Yes	No	No But
5. Is there evidence of a SLT management plan specifying type of intervention? <i>Answer 'no but' if intervention not indicated or refused.</i>			
6. Is there evidence of a SLT management plan specifying goals of intervention? <i>Answer 'no but' if intervention not indicated or refused.</i>			

<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>			
Teamworking			
<p>8. Is there evidence of SLT liaison with MDT eg attendance at MDT meetings, or similar forum?</p> <p><i>Answer 'no but' if no other member of MDT involved or client refused consent to discuss with MDT.</i></p>			
Evaluation/transfer of care/discharge			
<p>9. Is there evidence of discussion of outcome with the client?</p> <p><i>Answer 'no but' if client unable to participate owing to very severe comprehension/ cognitive problems, or no intervention given.</i></p>			
<p>10. Is there evidence of discussion of 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), no need to discuss with a carer, or no intervention given.</i></p>			
<p>11. Is there evidence of discussion of outcome with other professionals? (e.g. to GP, other SLT, intermediate care team)?</p> <p><i>Answer 'no but' if client refused discussion with other professionals or ongoing care not needed.</i></p>			
<p>12. Is there evidence that the client/carer was given a named SLT contact on discharge?</p> <p><i>Answer 'no but' if not discharged.</i></p>			



13. Is there evidence that a discharge report was given to the client/carer on discharge?

Answer 'no but' if client not discharged, died before discharge, or if client an inpatient or been transferred on within the service.

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