Position Paper

Speech and Language Therapy in Adult Critical Care

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CONTENTS

Executive Summary

A recent Department of Health (England) report on needs-led services for critical care states that "provision of diagnostic and therapeutic support is fundamental to the care pathway of critically ill people" and that "key professions in a critical care setting include … speech and language therapy" (Quality Critical Care 2005). The Royal College of Speech and Language Therapists (RCSLT) supports this report and believes that any person with critical care needs with communication or swallowing difficulties, has a right to access a professional with expertise in these areas.

The current situation of speech and language therapy (SLT) provision to people with critical care needs is inequitable with the majority of services not specifically funded for this client group.

This position paper highlights the SLT provision that should be available to ensure equity of access for people with critical care needs, and the key role that SLTs should have within critical care teams. These SLT services should be adequately planned and resourced, based on local demography and user need.

The paper is intended to advise and generate discussion between commissioners and service providers regarding providing SLT services that meet the requirements of people with critical care needs, their families, carers and other professionals in line with current national policies.

Communication and swallowing difficulties cause considerable distress in critically ill people. The following are quotes from service users:

> *"The worst …..… part of my stay in intensive care was having no ability to communicate….. and what did that mean? It meant no say in my care, no choices, no questions, no ability to reach out and no ability to be reached…..…"*
> **Adult, South London 2003**

> *"It was such a huge step forward when he could start to eat again. It was the first time he smiled since before his heart operation"*
> **Wife of person in critical care, South Manchester 2005**

Key Recommendations

- All people with critical care needs who have communication and/or swallowing difficulties due to organic, concomitant or psychogenic disorders, should have access to a timely and responsive speech and language therapy service.

- Commissioners should ensure that speech and language therapy services are incorporated in critical care service planning and development. Therefore speech and language therapy services should be examined to ensure they are appropriately resourced to provide quality care for people with critical care needs. This would include funding for appropriate speech and language therapy staff and equipment e.g. communication aids.

- Speech and language therapy services should provide equal access to intervention for both communication and swallowing difficulties.

- Organisations should develop critical care competency programmes for speech and language therapy staff.

- Speech and language therapy services need to engage in continuous appraisal of service provision and quality via clinical audit or research, e.g. auditing unmet need.

- Speech and language therapy services for people with critical care needs should be provided within an integrated multidisciplinary context to ensure the philosophy and goals of intervention are shared and consistent.

- Communication and swallowing are the responsibility of the whole team – the role of the speech and language therapist is to empower and educate others as well as providing direct specialist input as appropriate.

1.0 Mission statement

People with critical care needs who have difficulty with communication and/or swallowing require access to a funded, timely, responsive, appropriately skilled speech and language therapy (SLT) service in order to maximise their choice, participation, safety and wellbeing.

2.0 Definition

Critical care refers to the level of care given to a group of people who are deemed to be critically ill. In 2000, a Department of Health (England) report entitled "Comprehensive Critical care" recommended that "the existing division into high dependency and intensive care" services "based on beds be replaced by a classification that focuses on the level of care that individual people need, regardless of location". The classification system is as follows:

Level 0
People whose needs can be met through normal ward care in an acute hospital.

Level 1
People at risk of their condition deteriorating, or those recently relocated from higher levels of care whose needs can be met on an acute ward with additional advice and support from the critical care team.

Level 2
People requiring detailed observation or intervention including support for a single failing organ system or postoperative care, and those 'stepping down' from higher levels of care.

Level 3
People requiring advanced respiratory support alone or basic respiratory support together with support of at least 2 organ systems. This level includes all complex people requiring support for multi-organ failure.

Many people who are critically ill have requirements for support for their neurological, respiratory and digestive systems all of which can impact on their ability to communicate and swallow independently. Technologies to prolong life / enable clinical management of people who are critically ill may include mechanical ventilation, tracheostomy tubes, naso-gastric tubes and naso-pharyngeal airways. The presence of these can also impact on communication and oro-pharyngeal swallowing abilities.

3. Aetiology

There are 3 main causes of communication and / or oro-pharyngeal swallowing disorders in the critical care setting:

- Organic communication / oro-pharyngeal swallowing disorders such as those caused by Stroke, Head Injury, Guillian Barre Syndrome, Post surgical to oral cavity, pharynx or larynx, COPD (Martin-Harris-B 2001), ARDS, Spinal cord injury, tumours etc.
- Concomitant communication / oro-pharyngeal swallowing disorders such as the effects of critical care neuropathy (due to the disuse atrophy of striated muscle) or the effects of technologies to prolong life / enable clinical management of the illness such as mechanical ventilation, tracheostomy tubes, naso-gastric tubes and naso-pharyngeal airways. (Conlan and Kopec 2000, Pannunzio 1996)
- Psychogenic communication / oro-pharyngeal swallowing disorders such as those resulting from critical care psychosis or clinical depression.

In addition, within the Intensive Care Unit environment an undervaluing of communication can occur due to the level of arousal / medications (Hemsley B, et al 2001). Mechanically ventilated people report high levels of frustration when communicating their needs (Patak et al 2004).

4. Demographics

Approximately 18.5% of hospitalised people require treatment in a critical care environment (Level 1-3) (North West London Critical Care network critical illness audit 2003).

The literature reports a high range (50-70%) of aspiration reported in this population (Elpern et al 1987, DeVita and Spierer-Rundback 1990, Elpern et al 1994, Tolep et al 1996, Leder 2002, Gross et al 2003). Aspiration can frequently be seen in people requiring prolonged ventilation of three or more weeks (Elpern et al 1994, Tolep et al 1996, Leder 2002).

However, there have been numerous difficulties in trying to establish the true prevalence and incidence of aspiration in the mechanically ventilated population. The main reason for this is that aspiration is identified in different ways in different studies. Some studies employ bedside assessments (Elpern et al 1987) and others use instrumental techniques (Leder 2002, Gross et al 2003). In the studies that have employed instrumental techniques it is reported that aspiration can be “silent” or covert. This questions the veracity of those studies that have relied on overt aspiration detection; indeed, the true incidence of aspiration could be higher than is reported.

There are no studies to date that have examined the prevalence of communication difficulties in this population. However, the inability to speak and the associated communication difficulties that result are a major source of stress for people who are or have been intubated (Menzel 1998). An exit interview conducted in Derby

Hospitals NHS Foundation Trust found that 93% of people complain of communication problems on ITU (Derby report).

5. Philosophy Of Care

In 2000 the Department of Health (England) acknowledged that “comprehensive critical care is the complete process of care for the critically ill which focuses on the level of care that individual people need rather than on beds and buildings.” (Critical Care Programme: The role of healthcare professions within critical care services. AHP and HCS Advisory group. London: NHS Modernisation Agency; 2002.)

Many people who are critically ill have full decision making capacity and should have access to the same level of services and choices offered to less critically ill people in hospital. People who are critically ill have the right to maintain optimal use of their current communication and swallowing functions.

SLTs have the specialist skills to assess an individual's capacity to communicate and understand information and to facilitate optimal communication. The SLT is often the person best qualified to advise on the most effective means of presenting information and choices to the person in critical care who has a significant communication disorder. This facilitates the persons’ participation in their own care and decision-making process by maximising opportunity to exert free choice. This is a particularly important role for SLTs in relation to current legislation such as the Adults with Incapacity Act 2000 (Scotland), the Mental Capacity Act 2005 (England and Wales) and the Human Rights Act 1998.

The critical care context itself indicates the need for a flexible approach to service delivery, which reflects the limited windows of opportunity for SLT intervention. The intensity of the environment lends itself to a model of care, which can be labour intensive and requires extensive multi-disciplinary collaboration.

6. National Context

The specific value of SLT within the critical care setting has been highlighted in a number of recently published national documents.

The Department of Health (England) report entitled “Comprehensive Critical care” (2000) recommended that “an appropriately balanced team of staff including therapy professions and support staff is essential to the effective delivery of critical care services”.

In June 2002, the NHS Modernisation Agency produced a document detailing multi-professional AHP roles, which “offer unique value to patient care in the critical care setting”. This document was produced because “historically, the roles and value of AHP and HCS have been under acknowledged”.

The Department of Health (England) report, Quality Critical Care Beyond “Comprehensive Critical Care” (2005) states that “Many of these professions are not

employed directly in critical care but their input is essential to the management of all critically ill people. Their contribution must be resourced appropriately and taken into account during the planning and development of critical care services."

In 2001 the Welsh Assembly Government set up an All Wales Critical Care Development Group to look at the Critical Care Service in Wales. In 2006 WAG is due to publish "Designed for Life, Quality Requirements for Adult Critical Care in Wales".

7. The Role Of The Speech And Language Therapist

Speech and language therapists have clinical expertise in the areas of assessment and management of communication and swallowing difficulties whether they arise due to the nature of the underlying medical conditions, due to concomitant conditions, or due to the presence of equipment / technologies to support life. SLTs are therefore integral to the critical care multidisciplinary team and provide specialist knowledge and skills, which all people with complex communication or swallowing difficulties should be entitled to access.

The role of SLT in critical care is to:

- Use specialist skills to inform differential diagnosis regarding the nature and cause of communication and swallowing difficulties.

- Carry out instrumental specialised methods of assessment for swallowing difficulties such as Fibreoptic Endoscopic Evaluation of Swallowing (FEES) / Videofluoroscopy where appropriate.

- Provide specific communication and swallowing programmes /equipment/ advice to optimise and maintain function in liaison with the multidisciplinary team.

- Reduce the impact of the communication and/or swallowing difficulty "throughout the person journey from the hospital stay and into primary care" (Quality Critical Care Beyond "Comprehensive Critical Care" 2005) by providing support, advice and advocacy to the person, carers and multidisciplinary team.

- Provide training to the multidisciplinary team and carers regarding communication and swallowing difficulties, such as screening and managing non-complex difficulties.

As critically ill people may receive their care within levels 0-3 and in primary care, SLTs have a role to understand and work within the specific demands of the different environments. SLTs with specialist skills working within the field also have a role to provide training and support to other SLTs who are developing skills with, or services to, critically ill people.

8. The Benefits Of Providing A Speech And Language Therapy Service

8.1 Communication

SLTs can facilitate a person's participation and choice in treatment and recovery within the critical care setting by providing:

- A differential diagnosis of communication difficulties caused by or co-existing with the use of tracheostomy or mechanical ventilation.

- Specialist, individualised treatment/advice/strategies for the person to maximise communication ability including interventions to promote quality of life.

- Specialist advice/strategies to family members and multi-disciplinary staff to minimise communication difficulties between the person and others.

- Screening assessment of laryngeal injuries and concomitant conditions that may require further referral for clinical specialist investigations (i.e. ENT assessment or videostroboscopy).

- Alternative communication devices both low and high tech, where appropriate, to facilitate / augment communication.

SLTs have specialist skills in developing communication with even the most severely impaired people. They can offer assessments in communication with low and high tech aids, communication with ventilator adaptations (Tippett and Siebens 1991, Hoit and Banzett 1997), speaking valve / tube assessments (including Passy Muir), modification of environment and switch controls for people with very limited dexterity. SLTs can contribute to the team's management of the ongoing and changing needs of these people.

SLTs have specialist skills in assessing comprehension of language and language based higher level cognitive communication skills, both of which are crucial components in ascertaining a person's capacity to engage in consent discussions regarding their treatment and complex ethical decisions. SLTs are also skilled in facilitation of communication to enable people to participate in consent discussions. This role is clearly delineated in the Adults with Incapacity (Scotland) Act 2000 (Code of Practice 2002), which states: "A number of defining characteristics of incapacity clearly relate to communication skills, such as comprehension and expressive skills. Although many health and social care professionals have an awareness and training in human communication, clinical psychologists and speech and language therapists have a specialist knowledge and expertise. Where doubt exists, available expertise should be called upon to help medical practitioners and others who may require assistance in assessing a person's capacity."

By providing timely and ongoing assessment and intervention and providing effective communication strategies and/or aids there may be a reduction in the negative emotional responses (such as fear, anxiety, frustration) and an improvement in the

psychological well-being of the person, family and staff (Dikeman and Kazandjian,2003; Manzano et al, 1993).

By restoring or facilitating communication the person may participate more readily in treatment and provide valuable feedback on clinical issues such as work of breathing which can often be the clinicians greatest diagnostic tool (Isaki and Hoit 1997; Spremulli 2005).

8.2 Swallowing Disorders (dysphagia).

It is well documented and recognised that prompt intervention in the management of dysphagia can prevent costly and life threatening complications such as aspiration pneumonia (Barquist Leder 2002). Odderson (1995) showed that the incidence of aspiration pneumonia due to dysphagia could be reduced from 6.7% to 0% through effective management.
SLTs can minimise preventable secondary respiratory and nutritional complications of swallowing difficulties, which arise from or co-exist with use of tracheostomy/ventilator, by providing: -

- Specialist evaluation of swallow function, which may include instrumental assessment using Videofluoroscopy or FEES.

- Information to the multidisciplinary team on swallow status, to enable informed decision making regarding tracheostomy / ventilator weaning and commencement and timing of oral intake including postural advice for optimal swallowing function, the consistency of food, fluid and medication and methods of alternative feeding.

- Specialist individualised treatment, advice and strategies to maximise swallowing abilities including interventions to promote quality of life.

- Specialist advice on the management of oral hygiene and oral secretions where people are dysphagic and/or where there is a requirement for oral desensitisation e.g. the management of bite reflex.

- Specialist weaning intervention which may reduce the time taken to wean from the tracheostomy/ventilator and may potentially reduce the length of stay in critical care (Thompson – Ward et al 1999).

9. The Risks Of Not Providing A Speech And Language Therapy Service

9.1 Communication Disorders

9.1.1 Clinical risk: Frustration of critically ill person and staff with ineffective means of communication.

Establishing communication for critically ill people is largely overlooked in most critical care settings. At best, units may provide communication boards or rely upon attempting to lip read. Both of these options can be time consuming and frustrating,

leading to significant fatigue for the already fatigued person (Albarran, 1991). Nurses often report feeling frustrated and incompetent when they are unable to understand and meet people's needs (Bergbom-Engberg, I. and Haljamae, H. 1989).

9.1.2 Clinical risk: Inability to communicate effectively regarding clinical needs such as pain or to convey consent

Many people in ICU describe feelings of disempowerment and social isolation due to their inability to communicate effectively and because they are unable to express how they feel (Hemsley et al 2001). Studies that look at the impact of having communication difficulties in a critical care environment report that "anxiety, fear, insecurity and inability to sleep are all associated with being unable to speak" (Menzel 1994). A study by Bergbom-Engberg et al 1989, involving 158 people who had been treated with a respirator, found that inability to talk and communicate was the dominant reason for anxiety and/or fear during their treatment. It is assumed that communication problems only affect the person during the intubation period. However, there is evidence that, even after discharge from hospital the psychological well being of many people is affected. This often relates to communication difficulties experienced during their stay in critical care (Hemsley 2001).

9.1.3 Clinical risk: Increased length of stay in intensive care beds due to inability to participate in goal setting, clinical treatment and end of life decisions

Numerous studies have explored the length of stay in intensive care beds related to lack of participation in goal setting, clinical treatment and end of life decisions. Poor communication between the person who is critically ill and the physician, difficulties ascertaining the person's capacity for informed consent and a failure to understand their preferences were seen to contribute to length of stay in intensive care settings, particularly for those receiving longer-term interventions (Dowdy et al 1998). Teno et al (2000) reported that "among patients who spent 14 or more days on an ICU, a substantial majority had not talked with their physicians about their preferences or prognoses". Lilly et al (2000) reported that "more than 50% of patient days were spent providing advanced supportive technology for patients that did not survive". Increased communication with people about their values and preferences particularly related to end-of-life decisions were positively correlated with reduced length of stay (due to pro-active decisions regarding acceptance of palliative care) within the critical care environment (Dowdy et al 1998). Hemsley et al (2001) state that "having a severe communication impairment could affect the length of stay for a patient as negative mood would impact on the patients recovery or reduce the patients ability to participate effectively in therapy".

9.1.4 Clinical risk: Undiagnosed laryngeal injuries and concomitant voice disorders.

Lundy et al (1998) described a range of laryngeal injuries frequently resulting in communication disorders following decannulation from both short and long-term endotracheal intubation. Positive correlations were also made between laryngeal injuries and the presence of a nasogastric tube, however it was unclear if this was a

purely related to the presence of the tube or that people requiring enteral feeding were generally intubated longer term.

9.1.5Clinical risk: Compromised psychosocial well-being.
9.1.6 Clinical risk: Lack of reliable outcome measures.

Menzel (1997 and 1998) demonstrated that self-esteem of people in an ITU unit who were unable to speak was significantly associated with the person's emotional responses. Lack of communication can have a significant impact on psychosocial and emotional well being of the person and effect reliable measurement of outcomes. These types of measures, especially those looking at psychosocial factors, tend to be verbally dependant. If the person is unable to communicate, results will be skewed.

9.2 Swallowing Disorders (Dysphagia)

9.2.1 Clinical risk: Aspiration pneumonia including increased length of stay.

It is recognised that if the complex interrelationship between eating, swallowing and breathing is disrupted by the presence of assistive ventilatory technologies then impairment in swallowing can result (Dikeman and Kazandjian, 1995; Nishino et al 1989). SLTs can help to manage these difficulties by providing specialist skills in the assessment, diagnosis and management of the dysphagia. It is well documented and recognised that prompt intervention in the management of dysphagia can prevent costly and life threatening complications such as aspiration pneumonia. "Aspiration is the leading cause of pneumonia in the intensive care unit (ICU) and contributes significantly to the overall morbidity and mortality of the critically ill patient" McClave et al (2002). This complication can cause significantly longer hospital stays, thus increasing the cost of care (Carter-Young et al 1990). Odderson (1995) stated that people with aspiration pneumonia stayed in hospital on average 5.5 days longer.

9.2.2 Clinical risk: Compromised nutrition and hydration.

In Nutrition Support Guidance developed by the National Institute for Health and Clinical Excellence (2006), malnutrition has been linked to impaired wound healing, reduced muscle strength and fatigue, poor cough pressure, predisposing to and delaying recovery from chest infections and increased length of hospital stay: "In Critically ill patients, malnutrition is associated with impaired immune function, impaired ventilatory drive and weakened respiratory muscles, leading to prolonged ventilatory dependence and increased infectious morbidity and mortality". Malnutrition is prevalent in people on ICUs and has been reported as being as high as 40% (Heyland et al 2003). Comparative studies of critically ill people have indicated that "there is a significant reduction in infectious complications" if nutrition is delivered via the gut (enteral nutrition) (Heyland et al 2003). However "aspiration is the most serious side effect of enteral tube feeding…and has been shown to have a frequency of 40% in patients receiving enteral tube feeding." McClave et al (2002).

9.2.3 Clinical risk: Disuse atrophy.

Many people who have prolonged intubation with an endotracheal or a tracheostomy tube have swallowing disorders, predisposing them to aspiration. These swallowing deficits may be secondary to disuse muscle atrophy resulting in a weak and uncoordinated swallow response (DeVita and Spierer-Rundback 1990). Dikeman and Kazandjian (2003) also document how decreased base of tongue movement may occur as a result of continuous pressure by the endotracheal tube placed for mechanical ventilation. This effect begins on day one of intubation and impacts on swallowing. The tongue may become deconditioned but this may be amenable to indirect therapy e.g. oromotor exercises. In addition, people who are ventilator-dependent and tracheostomised may develop dysphagia as a result of disuse atrophy and desensitisation and these effects accumulate over time (Davis and Thompson Stanton 2004). SLTs have a vital role in assisting with the recognition, assessment and rehabilitation of these problems.

9.2.4 Clinical risk: Prevention of weaning.

Factors preventing weaning from mechanical ventilation and artificial airway include determining if the person has an inadequate cough and swallow and if they are systemically unwell e.g. due to pulmonary infection (Intensive Care Society Weaning Guideline). Aspiration pneumonia therefore impacts on ventilator status and may physically debilitate a person interrupting the weaning process (Dikeman and Kazandjian 2003). Delayed weaning, as a result of inadequate swallowing and risk of aspiration, is a common problem and is also associated with increased mortality and cost implications (Sheerson 1997). By assessing swallowing SLTs can advise on ways to minimise the risks of aspiration and contribute to the effective weaning process.

9.2.5 Clinical risk: Identification of complications of intubation.

The presence of tracheostomy and endotracheal tubes has been linked to damage to laryngeal protective mechanisms and can cause laryngeal injuries, which may cause dysphagia and aspiration. Larminat et al (1995) reported that the presence of an endotracheal tube can cause an “alteration in chemo and / or mechano receptors involved in the pharyngeal and laryngeal mucosa involved in the swallow reflex”. Sasaki et al (1977) reported that the glottic closure reflex, phasic inspiratory vocal fold abduction and altered sensitivity of brainstem reflexive responses were attributable to changes in ventilatory resistance produced by the presence of a tracheostomy tube. Shaker et al (1995) reported that “vocal fold adduction / abduction in persons with tracheostomies was significantly shorter in duration than that of normal volunteers”. Laryngeal tethering occurs according to Buckwater et al (1984) and limits the “laryngeal elevation necessary in closure of the supraglottic larynx”. Endotracheal intubation has also been closely linked with the presence of dysphagia and aspiration particularly in the immediate post extubation period (Leder et al. 2002, Ajemian et al 2001).

10. Medico-legal issues

It is not within the scope of this document to discuss at length the medico-legal issues associated with professional practice. The reader is directed to the following documents covering this area.

- Communicating Quality 3 (2006)
- HPC : Managing fitness to practise (2006)
- Department of Health. Practitioners with Special Interests

However, the reader should note that, as in all professional areas, the individual SLT's right to practise in the area of Critical Care is governed by the regulations of the HPC. The role of HPC is "to safeguard the health and wellbeing of people who use the services of the professionals registered with them. HPC maintains a register of Health professionals who meet the standards for training, professional skills, behaviour and health." (Your guide to our standards for CPD, HPC May 2006). Adherence to HPC's codes of practice is the professional responsibility of the individual therapist.
"When an AHP is employed by an NHS organisation, that organisation has vicarious liability for the AHP's actions. This is in addition to the AHP's professional accountability to the HPC." (Department of Health. Practitioners with Special Interests).

RCSLT is the professional body for SLTs. It "provides leadership so that issues concerning the profession are reflected in public policy and people with communication, eating, drinking or swallowing difficulties receive optimum care." (Communicating Quality 3: 4.1.1).
It is the responsibility of the individual SLT "to provide evidence-based services that anticipate and respond to the needs of individuals who experience speech, language, communication or swallowing difficulties." (Communicating Quality 3: 1.1).

Additionally "RCSLT provides an insurance policy that indemnifies all its practising members in the UK, Channel Islands and the Isle of Man. This covers proven liability arising from alleged professional negligence, breach of professional conduct and damage to property." (Communicating Quality 3: 4.1.4).

11. Workforce Development and Planning

The appropriate SLT skill mix must be provided and reviewed to meet the needs of people receiving care for critical illness regardless of the setting. However, it is not currently possible to recommend a notional caseload figure at an individual or service level. This is due to difficulties in establishing accurate prevalence and incidence data and regional variation in critical care service structure (see section 6).

The configuration of the SLT service will be different depending on the skill mix, local environment, health economy, staffing, resources and levels of expertise. One model of provision of care is where the skill mix exists across the SLT service, since many skills are transferable from one area of current clinical practice to another e.g. communication aid assessments, bedside swallowing assessment, voice management. Another model could be where highly specialised clinicians provide SLT services.

Clinical and or service leaders should carry out regular appraisal of skill mix in order to address fluctuations and changes in service needs. It is recommended that systematic review of service planning and succession planning must be regularly undertaken.

It is the responsibility of the SLT with expertise in critical care to share knowledge and expertise with SLT colleagues within the service and throughout local/regional networks e.g. RCSLT e-group, Specific Interest Groups, Journal Clubs, AHP Networks, mentoring, critical care networks, clinical supervision, RCSLT advisors.

It is recommended that SLTs routinely collaborate with other disciplines on training and development e.g. respiratory physiotherapists, critical care nurses, and anaesthetists.

There should be local discussion and negotiation regarding multidisciplinary role boundaries and associated competencies e.g. suctioning, initial cuff deflation assessment, provision of low tech AAC and screening of communication / swallowing disorders.

The RCSLT critical care working group has developed a Knowledge and Skills Framework (KSF) to act as a guide for clinical / technical skill development for SLTs developing skills in critical care (these are available to RCSLT members through the RCSLT website). The KSF competency document is designed to elaborate only clinical skills that are specific to critical care and therefore does not encompass more generic skills that may be incorporated in an individual clinician's KSF outline. Therefore this document is designed to have relevant sub-sections incorporated into an individuals overall KSF framework. It is recommended that managers consider using the framework to develop KSF outlines for a range of clinical staff grades from SLT assistant and newly qualified therapists to principal therapists.

11. Further information

This document complements several other publications, which are outlined below:

Clinical Guidelines (2003) – The guidelines contain recommendations that are explicit statements providing specific clinical guidance on the assessment and management of each clinical area. Each recommendation is supported by evidence from the literature or is based upon the consensus of clinical experts.

Communicating Quality 3 (2006). **Standards and guidelines that represent the benchmarks of SLT practice and provide criteria against which compliance can be judged.**
Communicating Quality 3 RCSLT's guidance on best practice in service organisation and provision. Royal College of Speech and Language Therapists. London, 2006.

RCSLT Workforce project – work in progress (due for publication 2007) – this project aims to define service models and skill mix required for SLT services to different client groups.

Fibreoptic Endoscopic Evaluation of Swallowing (FEES): The role of speech and language therapy - Policy Statement (2005).

Position paper on Videofluroscopy (RCSLT 2006) Currently under development.

Guidelines for the Development of Local Standards of Oral Health Care for Dependent, Dysphagic, Critically & Terminally Ill Patients. (2000) British society for disability & oral health. http://www.bsdh.org.uk/

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