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| **Check point** |  | |
| Student/Therapist: Therapist A  Supervisor: Therapist B  Date: Appraisal date | **Dysphagia Practitioner Level:**  **Level A []**  **Level B []**  **Level C Emerging []**  **Level C [X]**  **Level C Advanced []**  **Level D []** |  |
| **Clinical Competencies gained since last checkpoint**  eg I am able to independently take a clinical case history.  I am able to observe a mealtime using an observation checklist. | I have taken 10 case histories independently, and through discussion with my supervisor afterwards we are happy that the information gained was adequate and appropriate. They have then led to me accurately completing 5 supervised and 5 independent mealtime observations. I have started undertaking supervised assessments in the last 2 months.  Please see case example 1 (attached) for description of case history and observation information….*Therapist could attach small case study to demonstrate skills during appraisal as a supporting document.* | |
| **New knowledge and skills objectives**  eg To read about feeding techniques for children with dysphagia.  To practise a supervised, swallow screening assessment. | I have ready about different theories and information about feeding, eating and drinking, and methods for support in cases where children have difficulties, such as April Winstock’s work, Bobath, and FOTT. I have completed critical appraisals of these methods in relation to my specific client group and discussed and considered appropriate interventions for my patients.  Please see critical appraisal paper attached *– Therapist could attach 100 word critical appraisal of a particular theoretical technique* | |
| **Self-reflection on strengths and weaknesses**  critical evaluation of assessment and management of individuals with dysphagia | I have worked, with support from my supervisor with a 12 year old girl with special needs, as a result of cerebral palsy. Child C was referred for increased coughing at mealtimes and inability to manage foods other than puree. She is one of the cases I took a case history from independently but then my supervisor accompanied me during mealtime observation because I was concerned that this child was too complex for me to manage on my own. On visiting the family home I had concerns about her vulnerability and safety within the home setting, and became aware that this child my need MDT involvement to support her from the point of view of her home environment. In addition I was also concerned that this child had multiple medical conditions that would facilitate wider knowledge and confidence than I currently have, and again the intervention of the MDT. I attach an 1000 word reflection on my strengths and weaknesses in this case. In summary, my strengths have been that I have been able to take a focused and relevant case history, probing for the correct information in relation to child C’s dysphagia, and was able to make appropriate observations at mealtimes.  In terms of my weaknesses I do not have enough confidence and experience to work without support within the context of the vulnerable home environment, which may lead to safeguarding proceedings. While this child has many needs, currently her eating and drinking difficulties are paramount, and within the MDT service delivery the SLT in the lead professional. I do not feel I have the confidence and experience at this stage to carry out this role. As part of my development I would need to observe other more experienced therapists working in this role, and become more familiar with the issues and knowledge around safeguarding children. As part of my development targets for next year I would like to attend my safeguarding children level 3 training and observe more experienced therapists working within this context.  Clinically, during assessment, my strengths were that I was able to accurately assess and describe the child’s dysphagia and draft a relevant intervention plan for her eating and drinking. However, I needed support to look at the wider context and the impact of the dysphagia on the child socially and the potential impact on her family, and the way the family functions. I also needed to support to understand how the school environment and the home environment have different effects on the child’s eating and drinking, both positive and negative and to consider how we could learn from both environments to plan a more detailed intervention plan.  As part of my development I would like to undertake more shadowed assessment sessions and work on planning individualized intervention plans for the children I am working with. | |
| **Feedback from Supervisor** | Therapist A is progressing well with her dysphagia competency development. She has good core skills in dysphagia now and as she has identified, needs to further develop her independent assessment and intervention planning skills. She will do this in collaboration with her mentor and clinical supervisor. In terms of development targets for the coming year we have agreed the following:   * Undertake observed assessment (3 months) * Undertake unsupervised assessment but discuss with supervisor (3 months) * Undertake independent assessment but discuss in supervision sessions and ad hoc as required * Beginning planning intervention plans independently from now, but discuss with supervisor before rolling out for the next 3 months * Undertake safeguarding level 3 * Arrange one off observations sessions with Physiotherapist, Occupational Therapist, community nurse, arrange discussion session with psychologist regarding food, families, and potential social and emotional impact of eating drinking difficulties on family. * Prepare 2500 word literature review of the importance of food in families | |