Crib sheet for inputting therapy sessions

When completing CRF for **Day 15 follow-up**, you will be asked in **Section C**, from baseline to day 15:

**C1.** How many sessions of SLT input included dysphagia management

**C2.** Total no. of mins of SLT intervention

**C3.** How many sessions focussed on swallow ax/review

**C4.** How many sessions focussed on pt/family education

**C5.** How many sessions focused on swallow therapy (and the type of therapy delivered e.g. CTAR/Shaker, EMST, MDTP, Masako, Effortful swallow, Supraglottic swallow, Swallow stimulation, Oral trials, Chewing therapy, Oromotor exercises).

**Questions C1, C2 and C3:**

The Speech & Language Therapy team will typically write in block capitals the headings for the different types of assessment/intervention and therapy trialled with a patient. For Question C1 on the CRF, you would count all the usual care SLT entries from baseline to day 15 that mention dysphagia management. A typical set of therapy notes may look like the ones below:

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| --- | --- |
| SALT, WARD 4, SRU, FNCH  Pt seen awake & alert, NGT insitu, partner present. Consent gained.  SWALLOWING AX  - Level 7 meal (jacket potato with beans and tuna) = Pt able to feed himself using fork. Adequate mastication. Doing his usual baseline throat clearing which partner says is normal for him. Nil overt sign of airway penetration observed on 1/2 meal. Pt saying he felt it was the best meal he'd had.  Spoke with Dietitian afterwards - currently holding pt's feed and reviewing tomorrow to see if able to remove.  IMPRESSION: pt tolerating Level 7 diet textures well, ready for upgrade.  RECOMMEND:  \*\*\* Small single sips of Level 0 thin fluids from an open cup - prompt pt to take small sips  \*\*\* Level 7 regular diet  \*\*\* Supervision  \*\*\* Inform SALT if any concerns  SIS updated and put above bed. Informed hostess and updated hostess sheet and nursing handover.  Plan: check managing L0/L7 and liaise with dietitian re: intake. | |
| Patient Contact: 30 minutes |  |

In the example above, the session is a swallowing assessment, as shown by the title highlighted in blue. The total no. of minutes can be observed by looking the amount at the bottom of the notes (highlighted in green). There is no mention of the examples of swallow therapy in these notes so this would not be counted as a session that focused on swallowing therapy (Question C5 on the CRF). However, we would still count this as part of a usual care session (Question C1 on the CRF).

**Question C4:**

For Question C4 on the CRF, you may not always see an entry in capitals saying 'PATIENT EDUCATION' or 'FAMILY EDUCATION'. However, it is worth reading through the SLT notes, as sometimes they will give the patient or family education at set times e.g. Welcome meetings, family meetings. Or, it is built into the session. In the example below, you can see that the SLT spent time giving the patient and family education about the patient's swallowing (highlighted in grey). This would also count as usual care (Question C1 on the CRF).

|  |  |
| --- | --- |
| SLT, WARD 4, FNCH  WELCOME MEETING  SLT attended welcome meeting with pt, family & MDT.  SLT handed over re progress with trials however due to fatigue and HAP have not been able to progress these yet. SLT raised that due to this and time being mostly NBM except limited trials, team may consider PEG in future for pt. Wife seemed understanding. SLT explained that this may be a consideration further down the line and would not go ahead with anything without discussing formally with pt and family. SLT also highlighted that would continue to review pt with trials attempting to increase/upgrade as appropriate, however raised that have to keep pt safe as possible re chest status so progression may be slow. SLT also highlighted that if appropriate for PEG this is never permanent and can be taken out.  SLT spoke with family and pt in side room following meeting to ask if any further questions. Family showed some awareness of different levels of diet consistencies, had been informed about this at RDH. Pt asked why he can't have more textured food, SLT explained mostly due to fatigue and only able to manage limited amounts. Pt appeared understanding of this explanation.  Family concerned about PEG discussion but reassurance provided. May need further discussions re realistic expectations when clearer picture?  P: SLT to provide ongoing reviews of swallow and communication. | |
| Patient Contact: 60 minutes |  |

**Question C5 a) - k):**

Again, as with Question C4, you may not always see 'SWALLOWING THERAPY' written as a title within the SLT notes. In the below example, you can see that there is a clear title demonstrating the session was focussing in therapy, and is highlighted in blue:

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| --- | --- |
| SLTA,WARD 4,FNCH  S:Pt seen lying in the bed , consent gained for the session. Daughter present too.  Pt's daughter helped pt to sit upright in the bed, pt reported to be comfortable but sleepy.  -SLTA explained to pt about CTAR exercises, pt reported to do anything that will help her.  SWALLOWING THERAPY  CTAR hold: Pt managed to hold the ball under her chin for 15 seconds x 1, reported to find it very relaxing and fell sleep, woken by SLTA during this.  CTAR reps: pt managed to do 30 x 1, fell asleep, woken up by daughter but unable to continue with exercise due to fatigue.  A: Pt too fatigued / drowsy to carry out full exercises.  P: Continue with CTAR exercises and /k/ sounds when pt is not too fatigued. | |
| Patient Contact: 20 minutes |  |

Yet, in the session below, it's not specifically stipulated that the session was focussing on swallowing therapy. However, the type of therapy is usually capitalised by the SLT team within their notes to help identify which ones have been tried or how long they were being delivered. The therapy given can be seen highlighted in yellow - in the above example, CTAR has been given. In the below example, INTENSIVE SWALLOW THERAPY has been given, which is also known as MDTP.

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| --- | --- |
| SALT, WARD 4, SRU, FNCH  Pt seen awake and alert in bed, with SLTA.  INTENSIVE SWALLOW THERAPY:  SLT explained therapy technique to SLTA and advised pt to focus on point on wall to keep head still.  - Level 1 fluids (tsps) = throat cleared on 8th and coughed on 10th.  - Level 1 fluids (small sips) = coughed on 3rd and 5th sip, doing well on rest though delayed cough after last mouthful, though took very large mouthful as had drained cup.  - Level 0 thin fluids (tsps) = nil coughing observed on 10 tsps.  - Level 0 small (sips) = coughed on 2nd and 3rd sip, encouraged pt to use throat clear and swallow again technique on 5th sip and managed rest of cup.  IMPRESSION: pt responding well to intensive swallow therapy.  Plan: continue practising intensive swallow therapy with sips of L0. If consistently managing well, can considering moving on to thin fluids. | |
| Patient Contact: 10 minutes |  |

If you think a type of therapy has been delivered but it is not one of the ones listed on the CRF, you can always write it in section k)

