

# In search of consensus on aphasia management

Morag Bixley and colleagues discuss their analysis of current UK aphasia practice

**T**he Aphasia Therapy Specific Interest Group aims to provide a forum for education and discussion about impairment and social model-based therapy interventions for people with aphasia. The group's October 2010 study day attracted 95 SLTs from around Britain. We asked delegates to complete and return consensus questionnaires, so we could collect information about the therapists, their posts and their views about current aphasia management choices. De Montfort University, Leicester, gave ethical approval for the research.

## The respondents

Eight-six delegates, representing 55 different adult therapy services, completed the questionnaires. Sixty-four had been working for seven years or less and the range was between one and 38 years. Sixty-six worked for 10 sessions each week; 57 worked in hospitals and 29 worked in combined posts covering acute and community caseloads.

Respondents said they provided speech and language therapy to different specialist services within the hospitals in which they worked: cancer, cardiac, elderly, general medical, infectious disease, intensive,

neurological, stroke, renal and mental health care. They identified aphasia, cognitive communication impairment, dementia, dysarthria, dysphagia, dysfluency, tracheostomy speech, and voice as the main communication and swallowing difficulties they addressed in the acute setting. They also suggested the majority of therapy time was spent providing aphasia and dysphagia care. Despite individual differences, the average percentage of time devoted to language and swallowing difficulties was split equally.

There was little agreement about the name for the location where people with aphasia and dysphagia received therapy. Terms such as acute and stroke rehabilitation wards, stroke and elderly medicine units, stroke and orthopaedic units or neurological rehabilitation units appeared to be used interchangeably.

## Caseload prioritisation

Respondents commented that the factors influencing their caseload prioritisation included client need, client and family concern, severity of the communication impairment and new clients with language difficulties. Seventy-three said they would prioritise clients with dysphagia and those who were at risk of dysphagia. Forty-one said they were guided by national and departmental guidelines.

The prioritisation of swallowing therapy over language therapy could be



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attributable to the way in which stroke care is audited. In the Royal College of Physicians' Sentinel Audit (2010) two of the 12 key indicators (KI) of quality of stroke care focus on swallowing care:

- KI 2: 'Screened for swallowing disorders within first 24 hours of admission'
- KI 9: 'Swallow assessed by SLT within 72 hours'

Although the perceived relative importance of dysphagia is pragmatic and necessary, it is significant that 52 of our respondents said they felt unhappy they did not have time to provide communication management for people with aphasia because of the priority given to dysphagia care. These comments were spontaneous and were not made in response to a direct question.

## IN SEARCH OF CONSENSUS

86 Aphasia Therapy SIG delegates provided a record of current speech and language therapy practice

73 respondents prioritised clients with dysphagia

52 said they felt unhappy they did not have enough time to provide communication management for people with aphasia

The practices recorded could provide basis for future improvements to services


### Management choices

Respondents identified 172 different aphasia management choices in the acute setting. A grounded theme analysis identified 25 themes and we further sorted these into five main categories: support training and education (28%), therapy choices (24%), assessment (23%), multidisciplinary team working (16%) and speech and language therapy administration (9%).

These management choices are in line with current guidelines, such as those recommended by the RCSLT and RCP. It is apparent that the selection and prioritisation of appropriate choices from the diverse list of options present a challenge for therapists to overcome each time they meet a new client. Delegates identified that it is difficult to use the evidence base to support the use of one type of aphasia intervention over another in the acute phase. They suggested this was because the majority of aphasia research is directed at evaluating the usefulness of therapy at a time when clients are medically stable.

### Outcome measures

We asked delegates to describe the outcome measures they used to evaluate therapeutic input. Sixty-four indicated they used outcome measures and 50 of these used more than one type of measure (see table one for a summary). Despite the small sample of this study, the percentage of



*“Fifty-two of our respondents said they felt unhappy they did not have time to provide communication management”*

therapists measuring outcome appears to have increased since Hesketh and Hopcutt's 1997 notable study, where half of the 115 participants indicated they used outcome measures to evaluate the effects of their intervention and only a quarter of these measures were designed specifically

to measure aphasia intervention. Over the past decade, the increased use of outcome measures and aphasia-specific evaluation is almost certainly attributable to the increased use of audit within the healthcare system. The increased accessibility of formal published

impairment and living with aphasia-focused measures has made this shift in practice easier to accomplish.

**Successful transitions**

The last focus of the questionnaire into acute practice was on transitions between and within services. Respondents said the information they considered useful when referring clients to other therapists was: personal social, medical and diagnostic information (57%), assessment results (46%), therapy tried and response to that therapy (42%), current communication skills (39%) and recommendations for therapy (23%). Therapists reported they thought the transfer process worked best when transfers were written and verbal, and when they had secure and established professional links with the colleagues to whom they were referring.

**Conclusions**

The information we have recorded represents a record of speech and language therapy practice. This article highlights the challenges SLTs face in providing aphasia care and the choices they make. We would like our study to be used as a record of current practice, as a reference for a minimum standard or as a basis for future improvements to speech and language therapy services for people with aphasia. ■

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**References & resources**

Harbour R, Miller J. A new system for grading recommendations in evidence-based guidelines. *British Medical Journal* 2001; 323, 334-336.

Hesketh A, Hopcutt B. Outcome measures for aphasia therapy: it's not what you do, it's the way that you measure it. *European Journal of Disorders of Communication* 1997; 32:3, 189-202.

Royal College of Physicians. *National Sentinel Stroke Clinical Audit Round 7*. London: Royal College of Physicians, 2010.

**Table one: The number of therapists using different types of outcome measure**

Therapists	Outcome measure	Number of
Language measures	Formal assessments: Comprehensive Aphasia Test <sup>1</sup> Psycholinguistic Assessments of Language Processing in Aphasia <sup>2</sup>	25
	Visual Analogue Self Esteem Scale <sup>3</sup> Frenchay Aphasia Screening Test <sup>4</sup> Informal assessments	6
Scaled measures	Australian Therapy Outcome Measures <sup>5</sup>	18
	Therapy Outcome Measures <sup>6</sup>	9
	Rating scales	4
	Self rating scales	4
Goal-setting measures	East Kent Outcome System <sup>7</sup>	10
	Goal achievement	9
	Goal attainment scales <sup>8</sup>	7
Multidisciplinary measures	Functional Assessment Measure <sup>9</sup>	5
	Barthel Index <sup>10</sup>	3
	Multidisciplinary team outcome measures	3
Others	Client satisfaction questionnaires	5
	Communicative Effectiveness Index <sup>11</sup>	1
	Aphasia Framework for Outcome Measurement <sup>12</sup>	1

1 Swinburn K, Porter G, Howard D. *The Comprehensive Aphasia Test*. Hove: Psychology Press, 2004.  
 2 Kay J, Lesser R, Coltheart M. *Psycholinguistic Assessments of Language Processing in Aphasia*. London: Lawrence Erlbaum Associates, 1992.  
 3 Brumfitt S, Sheeran P. *Visual Analogue Self Esteem Scale*. Oxford: Winslow Press Limited, 1999.  
 4 Enderby P, Wood V, Wade D. *FAST: Frenchay Aphasia Test*. Chichester: Wiley Blackwell 2006.  
 5 Perry AA, Skeat J. *Australian Therapy Outcome Measures for Speech Pathology*. Melbourne: La Trobe University, 2004.  
 6 Enderby P, John A. *Therapy Outcome Measures: Speech-Language Pathology*. London: Singular, 1997.  
 7 Johnson, M, Elias A. *East Kent Outcome System for Speech and Language Therapy*. East Kent Coastal Primary Care Trust, 2002.  
 8 Gordon, JE, Powell C, Rockwood K. Goal attainment scaling as a measure of clinically important change in nursing-home patients. *Age and Ageing*, 1999, 28, 3, 275-81.  
 9 Hall KM. The Functional Assessment Measure. *Journal of Rehabilitation Outcomes* 1997; 1:3, 63-65.  
 10 Mahoney FI, Barthel D. Functional evaluation: The Barthel Index. *Maryland State Medical Journal* 1965; 14, 56-61.  
 11 Lomas J, et al. The communicative effectiveness index: Development and psychometric evaluation of a functional communication measure for adult aphasia. *Journal of Speech and Hearing Disorder*, 1989; 54, 113-124.  
 12 Simmons-Mackie N, Kagan A. *Application of the ICF in aphasia: AFROM*. Seminars in Speech and Language Therapy 2007, 28:4, 244-253.