



Show Notes - Episode 38
Broadening the Role of the SLP in Acute Care Assessment: A Conversation with Robyn O'Halloran

During this episode, Dr. Katie Strong, Assistant Professor in the Department of Communication Sciences and Disorders at Central Michigan University talks with Robyn O'Halloran about broadening the role of the SLP in acute care assessment.

Robyn O'Halloran is a Senior Lecturer in the Discipline of Speech Pathology at La Trobe University. She worked as an SLP in community and hospital settings before undertaking a M.Phil and PhD with Professor Linda Worrall on the role of SLP in the acute hospital setting. Robyn is the lead author of the Inpatient Functional Communication Interview: Screening, Assessment and Intervention, which will be published by Plural in November this year.

In this episode you will:

- learn the importance of supporting your patients participate in their health care while they are in the hospital and how that might impact their overall health outcomes.
- be challenged to imagine how your role as an SLP in acute care can broaden by addressing the barriers to communication in the hospital environment.
- hear about a new tool, the Inpatient Functional Communication Interview (IFCI) for assessment in acute care.
- listen to questions posed from SLPs working in acute care about IFCI

Robyn tell us about the 'aha' moment you had in realizing that a change was needed in the way we approach assessment in acute care?

RO: Well, there was an 'aha' moment actually that occurred back in the early 1990s. I was a relatively new graduate then and I was working in an acute and rehabilitation hospital. I received a referral to see a woman, and I think her name was Mrs. Thompson. She'd been admitted that morning with stroke and aphasia. So, it was a routine assessment. I picked up a screening test of aphasia and went down to the wards to see her. As I was conducting that assessment, it was immediately obvious to me that she had aphasia. But the more I tested her, the more worried and distressed she appeared, and that made me feel uncomfortable. Then I went to speak to her nurse afterwards, and I said to the nurse, "I've just seen Mrs. Thompson, she has aphasia, and she's having difficulty following complex instructions," and the nurse looked really irritated. She looked at me and said, "Well, she understands everything I say". It was at that point I realized that I just wasn't being useful. I wasn't useful to Mrs. Thompson, and I clearly wasn't useful to her nurse. I think what was worse was this



nagging feeling that not only had I not been useful to Mrs. Thompson, but the way that I had assessed her might have caused unnecessary distress and possible harm. That really bothered me. So, it prompted a lot of critical reflection on what our role is and what we should be doing, perhaps on that initial contact. It got me thinking, what does a patient need to be able to communicate about when they're in hospital, and what do their health care providers need to be able to communicate about with them in order for the person to get the health care they need? Is that what we should be doing in health care as a speech-language pathologist?

Can you talk a bit more about the importance of supporting a patient in participating by communicating about their health care vs. waiting until the next step or for discharge to community?

RO: Well that's the thing we usually address the impairment first. Often, we phrase it in a way of saying, 'we'll work on this receptive language impairment or this word finding difficulty in order to help the person communicate actively or participate in something in the future.' But really, when a person is in a hospital, they need to participate right then and right now, not sometime in the future. So, we don't have the luxury of spending a lot of time understanding the impairment and working on it. Sometimes people are only in hospital for a few days. So, we really need to think about how we can support the person with aphasia with the level of the impairment they have right there. And support their health care providers to communicate in optimal ways. I think what's interesting about that, is that if we can do that, do we change the person with aphasia's access to their health care in the hospital at that moment, and will that change their overall health outcomes? So, I think that that makes this shift feel quite important.

Could you describe your vision in broadening the role of the SLP in creating an accessible communicative environment in hospitals?

RO: I think it is a broadening of the role. I think the work that we do in identifying and diagnosing communication disability is really important. But there's scope there to do more than that, in terms of addressing the barriers to communication that exist in the hospital. I think a different approach is going to be necessary, and this is based on some work that we've done a couple of years ago. We screened patients admitted into stroke units, and we identified 55% of those patients had difficulty communicating about their health care with health care providers. So, then we looked at a general medical unit. So just typical cardiac, orthopedic surgery, or general medical patients. We screened those patients, and we identified 40% had difficulty communicating about their health care. So, if we've got 40-55% of patients, as a rough indication, having difficulty communicating about their health care, then I think we need a different service model. We need to keep some direct assessment in intervention of individuals, but we also need to look at system level change to modify the hospital environment, because there's no way we can feasibly address these issues at a one-



to-one level. So, it might mean things like routine communication partner training for health care providers, so they're already skilled and equipped with a range of strategies. You might look at other systemic sort of barriers in the hospital.

Could you give some examples about what that might include?

RO: I've started to work on this is by assessing an individual and their ability to communicate about their health care, and then trialing different communication supports and strategies to see what helps that communication be more successful. So, a lot of other strategies that I've started to use have been picture supports for explaining routine health conditions and also routine hospital procedures. So, picture supports that explain what is involved in an MRI, or what's involved in an NG tube insertion. Also, access to written information for people with memory difficulties, so that they can understand what's going to be happening to them in the next couple of days in hospital. The other thing that I use a lot is an assistive listening device, because many people admitted into hospital have hearing impairment. Often people don't bring their hearing aids into hospital. Hospitals are notoriously noisy, so they don't like to wear them, or they worry they're going to lose them. That sort of prompts you to think well, what can we do about the background noise levels in hospitals? How can we make the acoustic environment more supportive for people with communication disability? How can we ensure that there are safe, secure places for communication aids if people want to bring them into hospital? If they don't bring them in, what generic assistive listening devices or vision aids can we provide off loan while someone's in the hospital? The more you start thinking about this, there's just so much that we could be doing.

What is the vision for the acute care therapist? Are there different roles for acute care therapists in one hospital?

RO: We're at the very early stages of thinking about this. We're in the position of being able to be creative about how this might look. I think that it will look very different in different countries that work with different health care systems and have different billing arrangements around that. But as well as the traditional role of the speech pathologist doing individual assessments, there's the one way that we can start to shift this – by shifting our thinking about what we do on that first assessment. Should we be always doing an impairment-based assessment first off? Or, perhaps, should we be thinking about assessing whether the person can communicate their health care needs first, and maybe doing those in those impairment assessments of speech, language, or cognitive communication impairment? Then those more formal assessments later on? So, there's that question that we need to think about. But also, this broader role around modifying the communication environment. Well that, to me, sits well within quality and safety work that is already occurring in hospitals. So, we probably need to think about well, how do they bill quality work around ensuring all equipment in a hospital is compliant and safe? How do we ensure that all food and drink is at a certain standard? These



are all system level issues. I think we need to start thinking about creating communicatively accessible hospital environments from that systems perspective. We managed to fund different kinds of system level interventions. This is just another one.

This sounds like it would have a broader audience than a typical speech therapy caseload.

RO: When we've thought about this, it's anyone with any kind of communication, disability: hearing, vision, speech, language, cognitive, or communicative disability. But it also would help people who have different types of communication vulnerabilities, like people who come into hospital with low literacy or with low health literacy, people who come into hospital who may have little or no English or may not have sufficient proficiency in English to communicate about their health care, and people who have a different ethnicities or cultural backgrounds. So, the potential for it to benefit a much broader group of the population is there for sure.

What response have you had to this change in approach to assessment?

RO: I've had two types of broad responses as I've talked about this to people. Some clinicians love it and recognize that need to be able to communicate about your health care, and other clinicians don't. When I've talked to them, there have been two things. The first has been "I don't have time to do anything extra," and I totally agree. If we try and talk about this as an extra role on top of an already stressed and busy clinician, then it's not going to be viable. The other thing that clinicians have said to me is "that's not what I'm here for." I think that gets into the fundamental sense of what your role is in the acute hospital setting. I think some clinicians are attracted to work in the acute hospital setting, because it is medical, and because it does have a focus on diagnostic work. So, talking about the role in terms of supporting people living with communication disability and providing strategies to optimize what's possible now is a different role. I think, as we develop this role, we'll probably attract different types of clinicians into acute care practice. Because we need the combination - we need those clinicians who love the pace and the diagnostic challenges, but we also need clinicians who are tuned into modifying the environment to optimize communication.

Reading your work made me think about a recent experience that a member of our community aphasia support group had when admitted to the hospital with a heart issue. He has chronic and severe aphasia, many years post. He had significant challenges communicating his needs to hospital staff while he was admitted. The environment really failed him in communicating about his health care. Could share how an expanded role of the SLP might impact a situation like his?

RO: Unfortunately, the story that you've described is very common, because when people live with a lifelong communication disability and aphasia, for many people it becomes that. All the focus on the event, like the stroke, when it's newly acquired, but people need health care for



the rest of their lives. I think an expanded role would have potentially made an enormous difference to your community member. Imagine if on admission, or even prior to admission, he'd been alerted as someone who had a communication difficulty. So that immediately from day one, the staff would know that this was someone who needed communication support. Imagine then, if the speech-language pathologist came to see him and interviewed him about how well he was able to communicate his needs, and what supports he would need to do that in an optimal way. Then imagine if all the health care providers had communication partner training, so that they would then understand and be able to implement the SLPs recommendations around supports. Imagine if the cardiologist came to see your community member and had picture supports around what the heart condition was about and the different treatment options that were available. Those picture supports would have enabled him to point to some things to ask questions, to get clarification, or to indicate that he didn't want one treatment option but was willing to consider another. Pictures provide a way of having those conversations. The hospital may have even been able to give him an aphasia friendly consent form, in order to truly consent for whatever procedure was being offered. When you start thinking about it, it could have looked so different.

There's some compelling research that's been done that shows a clear association between having a communication disability in hospital and being less satisfied with your health care, and also with experiencing adverse events. There's a study done in Canada in 2008, that showed if you have a communication disability in hospital, you're three times more likely to have a preventable adverse event in hospital - that's stressful! It's risky and then adverse events do happen. It's not an environment for recovery and for well-being.

I wanted to alert the listeners that the show notes will have a reference list of many of the articles that Robyn and her colleagues have written. One that I'd like to bring your attention to is the 2017 *Topics and Language Disorders* article called *The Consequences of the Consequences*...which addresses the ongoing health challenges and essentially the impact on participation in life that aphasia can have when communication barriers are in place in the environment.

RO: In fact, Katie, that whole article was written, because like you, I was involved in a community group with people with aphasia and one of our members went into hospital and had a terrible experience. It really prompted me to think 'Wow, the impact of aphasia is cumulative over time and compromises health care in so many different ways.'

You and your colleagues have a new assessment tool that is launching soon the Inpatient Functional Communication Interview (IFCI). Could you talk about the idea of where this IFCI came from and how it was developed?



RO: It really started with Mrs. Thompson. Because I was determined. I was too early in my career to give speech pathology up, and I wanted to feel useful. So, we went about thinking about what people need to be able to communicate when they're in hospital and what health care providers need. So that's really where it came about. We developed it by doing a lot of observation in the hospital setting and observing patients with communication disability and their health care providers. Just communicating about health care and documenting what those situations were. On the basis of that, we developed a bedside interview that speech pathologist could conduct to help them investigate if the person is able to communicate about their health care, and if they weren't able to, what kinds of communication and supports and strategies could this clinician try in that moment to make the communication more successful. So that was the first tool we developed, which is the Inpatient Functional Communication Interview or the IFCI. We developed that in the early 2000s, and once we started working with that tool in practice, we realized we probably needed a screening tool to flag who needed an IFCI and who didn't. So, another tool we developed is a screening tool for nurses to use to identify people, after caring for them for one shift, about whether they have difficulty communicating with the patient or not. So that's the second tool. Then we've got two other tools in this resource, and they're for the speech-language pathologist. The third tool is a set of impairment rating scales. They're really designed for the speech pathologist to reflect back on the interview that they've conducted at the patient's bedside, and in thinking back on that assessment, reflecting on was there any evidence of an underlying speech impairment, language impairment, or cognitive communicative impairment to help, perhaps, inform more communication strategies that could be trialed further down the track, but also to start the clinician thinking about what might be the underlying impairments that might need further assessment down the track. The final tool is also a set of environment questionnaires, and that's for the clinician to reflect back on the interview and to think about the communication supports that worked, and the supports that didn't work, and to help clinicians think through which supports could be recommended to other health care providers, and which couldn't. We also can use those environment questionnaires as a way of screening the hospital for communication barriers for people with communication disability. So, it's a somewhat comprehensive set of tools to help us start thinking about and working in this way.

Could you give us some examples of what is on the interview?

RO: It starts off with a greeting and letting the person know who you are and what you want to talk to them about. Then it's about asking them if they understand or asking them to tell you what happened to bring them into hospital. Do they understand their medical diagnosis? Do they understand the implications of that? As the SLP you have obviously checked their notes thoroughly before you start this interview, so you've got a good idea of what the issues are. But then you're also checking to see if the person can ask questions about their care, if they can tell about pain or any kind of discomfort, if they can follow instructions, and if they can call



for a nurse. So, you'll end it anytime if the person is unable to do those things. You start thinking about, well, what can I do? How can I change the environment so that the person would be able to do that?

What is the difference between an interview and an assessment? Was the wording intentional?

RO: It was actually. Chris Code, who's one of the authors, suggested we call it an interview and the rest of us really loved that idea, because an assessment suggests a one-way experience with the clinician as the expert and the patient is being tested for a range of impairments. We wanted to shift that dynamic completely. So an interview suggests much more of a two-way, genuine interaction between two conversational partners. That allows the flexibility to try supports, look at the effect of them, and decide I'm not going to do that again or I'll try something else that works. So we thought 'interview' was a better word to capture what we're trying to do here.

With the help of Ellen Bernstein-Ellis, I reached out to two SLPs, Lyssa Rome and Madison Fox, who are working in acute care currently. After reading about IFCI they had a few questions from their view in the acute care units. Both Lyssa and Madison were curious about how using IFCI translates to meaningful goals for inpatients. In fact, Lyssa wondering if using IFCI would help shift SLP culture toward life participation instead of just impairment-level treatment. She reports her experience is that most SLPs in the hospitals where she works are not aware of LPAA.

RO: It's a great question, Katie, and conducting the interview really shapes how I think about goals and impact. That's one of the motivations for developing this is because what you assess, or what you do, does shape how you think about something. So, I remember doing one IFCI with a patient, and we weren't able to communicate successfully at all about pain and if she had pain or where it was and in talking to the nurses that was a concern for them as well. So, our goal then was to trial some gesture training with the patient and the nurses. I did a joint intervention. So, we actually were doing interventions. We thought during personal care in the shower was a brilliant time to practice gesturing. So, we used things like, this woman loved perfume, and she needed deodorant, so the nurses were saying, "Where would you like your perfume?" We were training gesture there as a way of creating repeated opportunities to practice gesture, so that when they said, "Where do you have pain?" we were training that understanding - that question and pointing response. So that really shifted my goals radically. Another person I interviewed was having difficulty recalling and remembering information about what was happening and going to happen in hospital. She was getting particularly angry, because she felt like nothing was being done. She was wasting her time being in hospital, because she had a significant cognitive impairment and couldn't remember what she'd been told. So, our goal was to provide support so that she could recall what's



happening for her in hospital. So, we created a hospital diary. We wrote down key information about what was happening that day and we worked with her to learn to refer to that diary to help remember what was going on. So, the goals do become very meaningful to address the issues that are of concern right there.

Lyssa and Madison also were curious about culture of the hospitals where IFCI has been used and wondered about the time constraints in settings where dysphagia services are emphasized. What were some of the barriers that have been experienced in implementing IFCI?

RO: What I've been talking to clinicians about is in initial contact with the patient, sometimes clinicians here in Australia will go and do an informal conversation as their first contact. So, we're talking to them about replacing that informal conversation with a semi-structured interview that is much more directed at addressing health care. So, using that time better. There's also some information you can glean through a dysphagia assessment about health care communication. So, when you get to do a bedside interview, you've already got some information about their ability to follow instructions or understand their medical diagnosis, because you can pepper in a dysphagia assessment with these kinds of questions if you're alert to them. But that will only get us so far, I think. I think it is about also recognizing that this is a really important role for us, and that there will be some cultural shift required in order to address it. So, I guess the main barrier that I've been coming up against, when I've talked about that need for a shifting role, is really a lack of awareness amongst SLP's and other health care providers about how many patients have difficulty communicating about their health care in hospital. I think it's a largely invisible population, because people with communication difficulties tend not to communicate about the difficulties they're having - the very nature of the problem. There's also a lack of awareness about the consequences for patients, but also for health care services, if communication doesn't go well. So, I think we need to do work around raising that awareness and raising the awareness about the consequences, to create a greater sense of urgency around being a priority in acute care.

When will the IFCI become available?

RO: We're launching it at ASHA this year in Orlando with Plural Publishing, which is very exciting. So, Linda Worrall, who's an author, and I will be there. We're really looking forward to seeing people in November.

Robyn, we typically ask a standard question of each of our podcast guests. My question for you today is: If you had to pick only one thing we need to achieve urgently, as a community of providers/professionals who support the Life Participation Approach to Aphasia, what would that ONE thing be?



I think it would be to keep reminding ourselves as SLPs that people with aphasia, and people with other lifelong communication disabilities, have the right to fully participate in their health care in hospital. They also have the right to the necessary accommodations to do that. If we keep that front and center, it will keep the fire in our bellies to fight for this change.

As we wrap up do you have any final thoughts you'd like to share with our listeners?

RO: Only that this could potentially be an exciting opportunity for clinicians interested in LPAA. It's a new frontier for us, I think, and something that will take time and it will take all of us.

A special thanks to Ellen Bernstein-Ellis for inspiring this episode and for inviting SLPs Lyssa Rome and Madison Fox to share their insights from the acute care perspective.

On behalf of Aphasia Access, we thank you for listening to this episode of the Aphasia Access Conversations Podcast. For more information on Aphasia Access and to access our growing library of materials go to www.aphasiaaccess.org If you have an idea for a future podcast topic email us at info@aphasiaaccess.org Thanks again for your ongoing support of Aphasia Access.

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