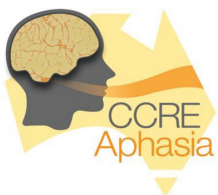


Aphasia Rehabilitation Best Practice Statements 2014

Concise supplement to the Australian Aphasia Rehabilitation Pathway

Aphasia Rehabilitation Best Practice Statements:

Concise supplement



www.aphasiapathway.com.au

BEST PRACTICE STATEMENTS

The **Australian Aphasia Rehabilitation Pathway concise Supplement** is a list of best practice statements for aphasia rehabilitation developed by the National Health and Medical Research Council (NHMRC) funded Centre for Clinical Research Excellence (CCRE) in Aphasia Rehabilitation (www.ccreaphasia.org.au). The concise supplement contains a list of 82 best practice statements presented in a table format within a Microsoft Word document. This format is intended as a practical implementation tool for clinicians and managers and may support audit or implementation of the best practice statements.

The concise supplement should be used in conjunction with either the online or comprehensive forms of the statements outlined below.

The **Australian Aphasia Rehabilitation Pathway website** www.aphasiapathway.com.au. The website contains a detailed introduction to the best practice statements, 82 statements with rationales, references and level of evidence for each statement. It also provides a variety of additional literature, links and practical resources for clinicians.

The **Australian Aphasia Rehabilitation Pathway comprehensive Supplement**. The comprehensive supplement is a PDF document that can be downloaded from the aphasia pathway website. It contains a detailed introduction to the best practice statements, 82 statements with rationales, the references and level of evidence for each statement. It also contains a reference list of studies cited in the supplement.

Disclaimer

The best practice statements are provided as a guide to appropriate practice, subject to the clinician's judgement and the client's preference in each individual case. The statements are designed to provide information to assist decision-making and are based on the best evidence available at the time of their development.

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Aphasia Rehabilitation Best Practice Statements 2014

1 RECEIVING THE RIGHT REFERRAL	
Community awareness of aphasia	
1.1	Community awareness of aphasia should be raised.
1.2	In awareness campaigns, it should be highlighted that aphasia can be an early and persisting symptom of stroke.
1.3	Appropriate stroke information should be given to people with aphasia and their families.
Communication training of health professionals	
1.4	Speech pathologists should provide communication training to people involved in the care of people with aphasia and provide strategies for enhancing communication.
Referral Process	
1.5	People with acute onset of aphasia should be suspected of having a stroke and transferred directly to a hospital with an acute stroke unit and admitted to the acute stroke unit.
1.6	All people post stroke should be screened using a valid and reliable tool that is sensitive to the presence of aphasia.
1.7	Any person with suspected aphasia should be referred to a speech pathologist.
1.8	Speech pathology services for people with aphasia, including those in the community, should be promoted to all potential referral agencies to ensure appropriate access to services.

2 OPTIMISING INITIAL CONTACT	
Initial Assessment	
2.1	People with suspected aphasia should receive assessment by a speech pathologist to determine the presence and severity of aphasia.
2.2	Hospital patients with suspected aphasia should receive assessment by a speech pathologist to determine the patient's ability to communicate their healthcare needs.
Initial Prognosis	
2.3	Individual language recovery cannot be accurately predicted immediately post stroke, therefore all individuals should be offered aphasia rehabilitation services.
Initial Management	
2.4	People with aphasia and their family/carers should be offered information about stroke and aphasia tailored to meet their changing needs using relevant language and communication formats.
2.5	Speech pathologists should offer support and training to family/ carers of people with aphasia to become skilled conversational partners.
2.6	Speech pathologists should provide hospital staff with individualised communication strategies that are tailored to enhance communication with each patient with aphasia.

3 SETTING GOALS AND MEASURING OUTCOMES	
Goal setting	
3.1	Goal setting should be a dynamic process that is reviewed across the continuum of care in order to reflect the client/family context, wishes and language recovery.
3.2	Therapists should explain the goal setting process to the person with aphasia and their family in an accessible way.
3.3	Collaborative goal setting between the speech pathologist, person with aphasia, their family and other team members should primarily focus on the goals identified by the person with aphasia/family with consideration of assessment findings.
3.4	Systems should be established to ensure involvement of people with aphasia and their family as part of the rehabilitation team.
3.5	The 'SMARTER' framework can be used to help ensure that goal setting is truly collaborative and client-centred.
Measuring outcomes	
3.6	Outcome measures for people with aphasia should be suitable to the construct being measured and psychometrically robust (reliable, valid and sensitive).
3.7	Outcome data for the person with aphasia should be reported in a full and unbiased manner to people with aphasia and their families.

4 ASSESSING	
4.1	The assessment process should be iterative and dynamic.
4.2	Assessment should be therapeutic.
4.3	All domains of functioning and disability should be considered for assessment.
4.4	The person with aphasia and key conversation partners should be invited to contribute to the assessment.
4.5	All assessment results should be documented and reported in an accessible format to people with aphasia and their families.

5 PROVIDING INTERVENTION	
5.1	People with aphasia should be offered therapy to gain benefits in receptive and expressive language, and communication in everyday environments.
5.2	People with chronic aphasia should be offered therapy to gain benefits in receptive and expressive language, and communication in everyday environments.
5.3	People with aphasia post one month should have access to intensive aphasia rehabilitation if they can tolerate it.
5.4	People with aphasia earlier than one month post onset could have access to intensive aphasia rehabilitation if they can tolerate.

5 PROVIDING INTERVENTION CONTINUED	
5.5	Aphasia rehabilitation should:
	a. Be tailored to the needs of the person with aphasia and the nature of their communication difficulty
	b. Address the impact of aphasia on functional everyday activities, participation and quality of life including the impact upon relationships, vocation and leisure as appropriate from post-onset and over time for those chronically affected
	c. Address the needs of family/carers
	d. Include information tailored to meet the needs of people with aphasia and their family/carers
5.6	Aphasia rehabilitation can include:
	a. Treatment of aspects of language following models derived from cognitive neuropsychology:
	i. Word retrieval deficits
	ii. Reading deficits
	iii. Writing deficits
	b. Treatment of sentence comprehension and production impairments
	c. Discourse treatment
d. Augmentative and alternative communication	
5.7	In addition to individual therapy delivered by a speech pathologists aphasia rehabilitation may include:
	a. Group therapy and conversation groups
	b. Computer-based treatments
	c. Telerehabilitation
	d. Trained volunteers

6 ENHANCING THE COMMUNICATIVE ENVIRONMENT	
6.1	Communication partner training should be provided to improve the communicative environment provided by frequent communication partners for the person with aphasia.
6.2	People with aphasia should have support material available to enable them to participate in communication.
6.3	Communicatively accessible environments should be provided for people with aphasia.

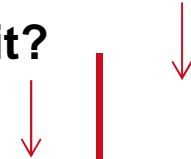
7 ENHANCING PERSONAL FACTORS	
Self-management	
7.1	People with aphasia and their families should be provided with self-management strategies.
7.2	Connections with appropriate social supports should be facilitated for people with aphasia and their families.
Culturally and linguistically diverse populations (CALD)	
7.3	Health care providers should consider both cultural and linguistic factors of the person/family with aphasia that may have an impact on service delivery.
7.4	Where the speech pathologist is not proficient in a language of the person with aphasia, a trained and qualified interpreter, knowledgeable with the specific requirements for speech pathology, should be used.
7.5	Where a patient reports having used more than one language pre-morbidly, comprehensive information about the patient's language history should be obtained.
7.6	Where possible, assessments should be used that are appropriate to the languages/dialects and cultural backgrounds of each client.
7.7	Where possible, treatment should be offered in all relevant languages and the relevant modalities.
7.8	Language behaviours unique to the bilingual person with aphasia such as translation, language mixing and switching should be considered in both assessment and intervention planning.
7.9	Speech pathologists should talk with the person with aphasia and their family about the roles the client has in the family and community.
7.10	Speech pathologists should explain terminology in a way that is relevant and culturally appropriate.
7.11	Speech pathologists should be trained in cross-cultural competence with particular reference to Aboriginal and Torres Strait Islander cultures.
7.12	Speech pathologists should implement local protocols that guide working with Aboriginal and Torres Strait Islander communities.
7.13	Speech pathologists should routinely check Aboriginal and Torres Strait Islander status in clients' health records and with the clients themselves.
Working with people from Aboriginal and Torres Strait Islander backgrounds	
7.14	Speech pathologists should offer the involvement of an Aboriginal Liaison Officer (ALO) where possible to advise on cultural issues and liaise with client and family.
7.15	Where the speech pathologist is not proficient in a language of the person with aphasia, a trained and qualified interpreter, knowledgeable with the specific requirements for speech pathology, should be used.
7.16	Speech pathologists should explain speech pathology terms in a way that is relevant and culturally appropriate to the Aboriginal and Torres Strait Islander person and their family.
7.17	Speech pathologists should include some yarning time with Aboriginal and Torres Strait Islander clients and their family during the assessment process i.e. time talking about personal backgrounds (both therapist and client).
7.18	Speech pathologists should talk with the Aboriginal and Torres Strait Islander person with aphasia and their family about the roles the client has in the family and community.
7.19	Speech pathologists should take a holistic approach to assessment and management that is aligned to an Aboriginal and Torres Strait Islander worldview.
7.20	Where possible, assessments should be used that are appropriate to the languages/dialects and cultural backgrounds of each Aboriginal and Torres Strait Islander client.

7.21	Speech pathologists should develop an awareness of local Aboriginal health services and Aboriginal specific social services.
7.22	Speech pathologists should develop reflective practice skills so that they learn from each experience with an Aboriginal or Torres Strait Islander client and improve the service they provide with each new client with guidance of a mentor.

8	PLANNING FOR TRANSITIONS
8.1	Planning for the next phase should be initiated as early as possible.
8.2	Speech pathologists should be part of the discharge planning team and adopt an advocacy role to promote optimal care.
8.3	During transitions, timely, up-to-date, accurate and appropriate patient-related information should be shared with the receiving healthcare providers.
8.4	At the time of any transition, written information that includes current diagnosis, action plans, follow-up care, and goals should be provided to the patient, family and carers.
8.5	The speech pathologist, as part of an interdisciplinary team approach, should contribute information about the communication skills of the person with aphasia that may influence appropriateness of discharge.
8.6	Services that provide early supported discharge should ensure that the person with aphasia and their family is still carefully linked in with ongoing supports and appropriately prepared for the transition.
8.7	The speech pathologist should endeavour to connect the person with aphasia and their family with other people with aphasia, aphasia groups or support organisations.
8.8	As part of the interdisciplinary team, the speech pathologist should, for legal issues, document all observations regarding the person's ability to understand written and verbal information and express their wishes.
8.9	People with aphasia and their families/carers should have access to a contact person for any queries post-discharge and know how to self-refer to appropriate speech pathology services after discharge if they feel further rehabilitation is required.

**Importance
1(not at all)- 5 (very)?**

Do you do it?



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