SUBJECT: SPEECH-LANGUAGE PATHOLOGY EVALUATION PROCEDURES	REFERENCE #8202
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DEPARTMENT: REHABILITATION SERVICES	EFFECTIVE:
APPROVED BY:	REVISED:

PURPOSE:

Functional assessment, evaluation, reassessment and treatment of each identified patient will be performed in a manner that will ensure a comprehensive method of data aggregation, analysis, interpretation and professional recommendation for benefit of the patient.

POLICY:

The Speech-Language Pathology Department conducts screening and evaluations to diagnose speech, language, oral and pharyngeal sensorimotor competencies and cognitive abilities in a wide variety of patients.

PROCEDURE:

- Evaluation Process:
    - All physician orders will be initiated within a 24-hour time frame of receipt by the Speech-Language Pathology staff during regularly scheduled department hours of operation. Evaluation and treatments of patients occur in the patient room or in Rehabilitation Services.
    - The Speech-Language Pathologist will verify each order for accuracy against the actual physician order written in the medical record. The medical record will be reviewed with relevant information recorded (in a comprehensive format) on the Speech-Language Pathology Evaluation form. A verbal report of the patient's current status will be obtained from the attending nurse.
    - The Speech-Language Pathologist will determine the most appropriate evaluation, materials and instruments to utilize for the evaluation of the patient as an individual.

- Evaluation Content:
  - Speech-Language/Cognitive Evaluation Form will include:
    - Patient demographics
    - Current and past medical history, including living situation and medication organization system
    - Oral peripheral examination
    - Speech-language production evaluation
    - Receptive and expressive language evaluation
    - Cognitive evaluation, including:
      - Immediate, delayed and working memory
      - Auditory recall
      - Higher leveling thinking, such as convergent and divergent thinking
      - Organization
      - Discrimination
      - Verbal problem solving
      - Reading comprehension
      - Following written directions
    - Clinical impressions and recommended interventions, specifically discharge planning recommendations
    - Assessment of augmentative means of communication

- Bedside Swallowing Evaluation will include:
  - Patient demographics
  - Current and past medical history
  - Oral peripheral examination
  - Swallowing stages (oral, pharyngeal evaluation) with multiple consistencies, including puree, thin via cup and straw, thickened (if needed), solid or soft solid (if needed)
  - Clinical impressions and recommended interventions and appropriate diet

- Projected Prognosis - Documentation and Communication:
  - The Speech-Language Pathologist will document findings in a written report immediately upon completion of the evaluation.
  - The written report will be filed under the Rehabilitation component of the medical record.
  - The attending physician and patient care unit RN will be verbally notified of the evaluation findings.