Simulation-based Learning Program

Clinical educator workbook: Day 2

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Day 2 timetable - overview

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8:45am	**Simulation 3:** Mr Tom Jones (student role-play)
10.15am	Morning tea
10.30am	**Simulation 4:** Mr Michael Goodman (student role-play)
12:00pm	LUNCH
12:45pm	**Simulation 4 (continued):** Mr Michael Goodman
3:00pm	Afternoon tea
3:15pm	Preparation for Day 3
4:30pm	Close of Day 2

Day 2 Run sheet

Time	Simulation team	Activity/Simulation	Location	Student learning focus	Debriefing tool
8:30am-8:45am	Clinical educator	General preparation time	Teaching room	Discussion regarding learning for the day: opportunity to implement aphasia therapy and formal motor speech assessment.	
8:45am – 9:00am	Clinical educator	**Prebrief simulation 3: Mr Tom Jones** • Prebrief workbook activities	Teaching room	1. Reintroduce Simulation 3 and case discussion. 2. Being able to work within a pair.	
9:00am – 9:45am	Clinical educator All students – role play in pairs (student pairs to remain the same from Simulation 2, Day 1)	**Simulation 3: Mr Tom Jones** → *Role play* Case: Mr Tom Jones. 65yo male. 3/52 post left hemisphere stoke. Characteristics of anomic aphasia. Inpatient on NSHS rehabilitation ward. Students conduct therapy session in pairs as role-play. Both students have opportunity to play "Tom" and the "student clinician". As the student clinician, students will conduct the session as per plan provided.	Speech Pathology office/treatment rooms. Individual treating bays required.	1. Clearly explain therapy task requirements to patient with aphasia. 2. Adapt session requirements appropriately to reflect patient needs. 3. Describe appropriate follow-up plan post session and effectively communicate to patient.	

Time	Simulation team	Activity/Simulation	Location	Student learning focus	Debriefing tool
		Clinical educators to be roaming between work stations observing and offering feedback/support. **Simulation timing:** 45 mins simulation (15 mins per role of 'student clinician' and 'Tom')			
9:45am – 10:15am	Clinical educator All students – large group discussion	**Debrief simulation 3** • Complete debrief workbook activities.	Teaching room	1. Facilitated discussion regarding the session guided by debriefing tool.	Appreciative Inquiry or Advocacy Inquiry
10:15am	Morning Tea (15 minutes)				
10:30am – 12:00pm	Clinical educator All students – large group discussion	**Prebrief simulation 4: Mr Michael Goodman** • Prebrief workbook activities (Qs 1-4). • Work through completed FDA-2© rating form with students and discuss results.	Teaching room	1. Identification of key information from medical chart. 2. Case discussion including patient journey (refer to information on p.13) 3. Review completed FDA-2© rating form and assessment report. 4. Analyse and interpret case history information and assessment data with support from the clinical educator.	

Time	Simulation team	Activity/Simulation	Location	Student learning focus	Debriefing tool
12:00pm		LUNCH (45 minutes)			
12:45pm – 1:15pm	Clinical educator All students – large group discussion	**Prebrief simulation 4 (cont) 4: Mr Michael Goodman** • Continue Prebrief workbook activities – Q5 (i.e. develop session plan and therapy resources for session with Michael). • Following review and discussion of assessment results and progress report, students prepare therapy session plan (targeting motor speech) and appropriate therapy resources.	Teaching room	1. Develop an appropriate therapy session plan for a patient taking into consideration i) assessment data ii) patient goals. 2. Develop appropriate therapy resources to conduct session. 3. Discuss criterion levels.	
1:15pm – 1:45pm		**Simulation 4: Mr Michael Goodman** → *Role play* Case: Mr Michael Goodman. 26yo male. Presenting 5 months post TBI from MVA. Dysarthria and cognitive communication deficits. Outpatient of NSHS rehabilitation unit.	Speech Pathology office/treatment rooms. Individual treating bays required.	1. Conduct a motor speech therapy session clearly explaining therapy task requirements to the patient, appropriately adapting session requirements to reflect the patient's needs.	

Time	Simulation team	Activity/Simulation	Location	Student learning focus	Debriefing tool
		Students conduct therapy session in pairs as role-play. Both students have opportunity to play 'Michael' and the 'student clinician'. As the student clinician, students will conduct the session as per their developed plan. Clinical educators to be roaming between work stations observing and offering feedback/support. **Simulation timing:** 30mins (15mins in each role)			
1:45pm – 3:00pm	Clinical educator All students – large group discussion	**Debrief simulation 4** • Complete debrief workbook activities. • Complete progress note for session. • Students to work individually to write progress notes.	Teaching room	1. Write full progress note based on session.	Plus Delta or Pendleton
3:00pm		Afternoon tea (15 minutes)			
3:15pm - 4:30pm	Clinical educator All students –large group discussion	**Preparation for Day 3** • Inpatient acute ward (simulation lab).	Teaching room	1. Document statistics. 2. Review relevant bedside screening assessments to be used in an acute ward.	

Time	Simulation team	Activity/Simulation	Location	Student learning focus	Debriefing tool
		• Review swallowing, speech and language screening tools in student workbook. • In pairs students to practice administering clinical swallow exam, motor speech and language screeners. **Statistics:** Students document stats from Day 2 in workbook.			
4:30pm		**Close of Day 2**			

SIMULATION 3: Mr Tom Jones

Patient information	• Tom is a 65 year old gentleman who suffered a left hemisphere stroke 3 weeks ago. • His wife, Fran found him slumped and unresponsive in his armchair when she returned home from doing the grocery shopping. • An ambulance was called and Tom was admitted to Emergency Department of the National Simulation Health Service (NSHS) – the local tertiary hospital. • On admission Tom has had a CT scan that confirmed the stroke. • Tom was then admitted to the Acute Stroke Unit (ASU) and remained there for 2 weeks. • Tom was then transferred to the Rehabilitation Unit where he has been for one week. He has had initial formal assessments conducted by speech pathology, physiotherapy and occupational therapy. • Tom has not been seen by speech pathology since the assessment.
Overview of the simulation Role-play	This simulation is set following 2 weeks of rehabilitation services. The speech pathologist, physiotherapist and occupational therapist have now commenced rehabilitation with Tom. Tom has recently met with the speech pathology student clinicians where he has been provided with the results of his formal language assessment, developed intervention goals and completed impairment-based therapy tasks. As the student clinician, the student will conduct their planned rehabilitation session with "Tom". The student clinicians should demonstrate appropriate communication skills, an ability to develop rapport with a client and an ability to clearly explain task demands. At the end of the session, the student clinician should provide information to "Tom" regarding a follow-up plan. After participation in this clinical simulation, students will be able to: 1. Clearly explain therapy task requirements to a patient with aphasia. 2. Appropriately adapt session requirements within-session to reflect patient needs. 3. Describe an appropriate follow-up plan post session and effectively communicate this to a patient with aphasia. The student clinicians will have an opportunity to act as the treating student clinicians and as the simulated patient "Tom". Each session should take 15 mins i.e. each pair will be engaged in the simulation for 30mins in total = 15 mins as student clinician and 15 mins as 'Tom'.

Setting		The room will be set up with individual Speech Pathology bays for the students to complete the role-play simulation.
Learning objectives	After participation in this clinical simulation, students will be able to: 1. Clearly explain therapy task requirements to a patient with aphasia. 2. Appropriately adapt session requirements within-session to reflect patient needs. 3. Describe an appropriate follow-up plan post session and effectively communicate this to a patient with aphasia.	
Debriefing model/s	Appreciative Inquiry or Advocacy Inquiry	

Debriefing Simulation 3

Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
After participation in this clinical simulation, students will be able to: 1. Clearly explain therapy task requirements to a patient with aphasia. 2. Appropriately adapt session requirements within-session to reflect patient needs. 3. Describe an appropriate follow-up plan post session and effectively communicate this to a patient with aphasia.	**Appreciative Inquiry** The assumption of appreciative inquiry is that in every situation, something works. This approach looks for what works in a situation or learning environment and focuses on doing more of this.	**Thinking about that simulation** • Tell me what worked really well in that simulation? • What did you as a person, or you as a group do well? • What made it work well? • Describe a specific time when you felt you/your group performed really well. What were the circumstances during that time? • What do you think contributed to this working so well? • Do you have some ideas about how you could use/do more (*what worked well*) within your clinical practice?	
		OR	
	Advocacy inquiry This approach is based on **advocacy** from the facilitator in the form of objective observation and **inquiry** which explores with the learner what happened in a curious way before thinking about positive ways forward.	**Thinking about that simulation** • How did that feel? • Can you summarise what your simulation was about so we are all on the same page? • I observed you (group or individual) doing….. • I was really comfortable with this because …….. OR	

Debriefing Simulation 3

Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
		- I was concerned about this … because ……… - Tell me why … happened? Help me understand why … happened? (Ask the group for input) Has this happened to anyone else? (Brainstorm solutions) How have you dealt with this in the past? Can anyone think of any solutions or strategies? Summary and wrap up. In summary, today we learned about………..	

Clinical educator self-evaluation at conclusion of simulation

1. What worked well with this simulation?
2. What didn't work well with this simulation?
3. How was the timing for this simulation?
4. What would you do differently next time?

Session plan: Mr Tom Jones

Session element	Goal / Activity	Time	Materials	Criterion	Theoretical basis & rationale
1. Introduction and discuss outline of the session	• Student clinician to introduce him/herself to Tom and outline the aims of the session.	1-2 mins	N/A	N/A	• Tom presents with impaired verbal expression skills. Picture naming and convergent naming tasks target neural networks to improve lexical semantic access.
2. Activity 1: Picture naming	• Students to engage Tom in a picture naming activity to improve lexical semantic access. • Student clinicians to use given cueing hierarchy to support Tom to name pictures of basic, everyday objects. • Students may provide more or less support depending on Tom's needs and should identify the most beneficial types of cues to use with Tom based on performance.	5-8 Mins	Picture cards Cueing hierarchy Pens/ paper	90% accuracy in naming pictures of basic everyday objects with nil prompting.	• Semantic and phonological cues were found to assist Tom during the WAB-R assessment and these cueing strategies may assist Tom to identify target words during session. • Cueing strategies should be faded over time (as appropriate) so that Tom does not become reliant on clinician prompting. • Student clinicians can use amount and type of prompting to grade task demands and increase / decrease task complexity relative to patient performance.
3. Activity 2: Convergent naming / sentence completion	• Student clinician's to engage Tom in a convergent naming or sentence completion task to target improved lexical semantic access. • Students to use semantic and phonological cues to assist Tom to identify the correct word throughout the session. Students should aim to reduce the level of cueing over time.	5-8 mins	Convergent naming and sentence completion worksheets	90% accuracy in identifying target word with nil further semantic or phonological cueing provided by student clinician	
4. Questions & treatment plan	• Student clinician to answer any of Tom's questions, provide overall feedback regarding performance and outline plan for further therapy sessions.	1-2 mins	N/A	N/A	

PLAN: (1) Daily therapy in inpatient rehabilitation setting targeting areas identified in today's session.

Therapy tasks

Note: all therapy resources are located at the back of the student workbook for Day 2.

Picture naming – list of picture cards

1. TV/Television	16. Fork
2. Remote	17. Clock
3. Toothbrush	18. Ball
4. Toothpaste	19. Book
5. Hairbrush	20. Socks
6. Phone	21. Shoes
7. Bed	22. Jug
8. Chair	23. Hat
9. Couch	24. Cardigan/Jumper
10. Table	25. T-shirt/Shirt
11. Lamp	26. Plant/Flower
12. Glass	27. Watering can
13. Plate	28. Newspaper
14. Spoon	29. Pen
15. Knife	30. Scissors

*picture cards are located at the back of the Day 2 student workbook.

Convergent naming

Target: Word retrieval; semantics

Instructions: Name the object which is being described.

1. It swims in the ocean. You can eat it. ___(fish)_____
2. It is a yellow and green vegetable. It comes on a cob. ___(corn)_____
3. It shines in the night sky. There are many of them. ___(star)_____
4. You put a key into it to open it. ___(lock)_____
5. It's an animal. It's coat is made of wool. ___(sheep_____
6. Looks after patients in a hospital. Works with doctors. ___(Nurse)_____
7. You use it to clean your teeth. You put toothpaste on it. ___(toothbrush)____
8. A body part attached to your leg that you use to walk. ___(foot)_____
9. You read it. It can be delivered daily to your house. ___(newspaper)_____
10. It falls from the sky and is wet. ___(rain/snow)_____

Phrase completion

Target: Word retrieval; semantics

Instructions: Complete these sentences with the correct word.

1.	Knife and…	**Fork**
2.	Black and…	**White**
3.	King and	**Queen**
4.	Girls and…	**Boys**
5.	Sugar and…	**Spice**
6.	Up and…	**Down**
7.	Shoes and…	**Socks**
8.	Cat and…	**Dog**
9.	Cup and…	**Saucer**
10.	Grandmother and…	**Grandfather**

SIMULATION 4: Mr Michael Goodman

Patient information	• Michael is a 26 year old male who suffered a TBI (Diffuse axonal injury (DAI) – areas of petechial haemorrhage in subcortical white matter and thalami), 6 months ago following a single vehicle high speed MVA.
	• He was intubated at the scene with GCS 3 and airlifted to the Intensive Care Unit (ICU) at the NSHS Hospital.
	• Prior to his accident Michael was working for a property company in their marketing team. He had been with the company since graduating 4 years prior. He was living in an apartment with two friends. He played for a local soccer team.
	• No significant medical history.
	• Michael spent almost 1 month (28 days) in an induced coma in the ICU. His ICU stay was complicated by ventilator associated pneumonia (VAP) and sepsis. A surgical tracheostomy was performed on day 14 in ICU.
	• Slow neurological recovery.
	• Once medically stable and weaned from ventilation he was discharged to the acute neurosurgical unit where he remained for 2 months. He was weaned from the tracheostomy during this time, successfully decannulated, and oral intake commenced prior to admission to the Brain Injury Rehabilitation Unit (BIRU) to continue rehabilitation.
	• On admission to BIRU Michael presented with:
	a. bilateral hemiparesis (greater on the right, than left), ataxia, double vision requiring an eye patch,
	b. wheel chair bound, hoist transfer,
	c. reliant on nursing staff for all ADLs,
	d. reduced insight into situation,
	e. continued to present with behaviours indicative of post traumatic amnesia,
	f. mild dysphagia, dysarthria and cognitive-communication deficits on informal screening.
	• He received multidisciplinary team (MDT) management during his BIRU inpatient stay. Goals for admission included maximising physical independence, returning to normal diet and fluids and to be able to return to social interactions with friends i.e., attending soccer match with friend During his admission he participated in assessment and management of communication and swallowing including the FDA-2 © and CLQT©. He completed intensive daily therapy targeting his speech and cognitive communication deficits this included individual sessions and group therapy.
	• Michael was discharged from inpatient rehabilitation after 3 months.
	• On discharge his oropharyngeal dysphagia had resolved and he was tolerating a full diet and thin fluids. His communication on discharge was functional for communicating with family and friends. However, he continued to present with dysarthria and

	cognitive communication deficits which would limit his ability to successfully return to social, home and vocational roles.
	• It was recommended that Michael continued to be seen by speech pathology as an outpatient in order to maximise his communication independence and autonomy.
	• His workplace has offered him a few hours work/week with support and supervision of the team and manager. This will be discussed with Michael and the team.
Overview of the simulation Role-play	This simulation is set in an outpatient speech pathology rehabilitation officer. This is the second time he has been seen as an outpatient. The first time, the FDA-2© was repeated (see completed rating form below). The speech pathologist, who completed the assessment, has written a progress and assessment report (see below, and in patient medical file). The students will be required to review the completed FDA-2© rating form and assessment report and develop an appropriate therapy session plan. In pairs, the students will then be required to role-play the planned session. The students will alternate playing the 'student clinician' and 'Michael'. The student clinicians should demonstrate appropriate communication skills, the ability to develop rapport with a patient, the ability to discuss assessment results and intended treatment plan with a patient and the ability to clearly explain task requirements and modify therapy tasks appropriately. The simulation will run for 30mins in total. Each student should have approximately 15 minutes playing each role.
Setting	The room will be set up with individual speech pathology bays for the students to complete the role-play simulation.
Learning objectives	After participation in this clinical simulation, students will be able to: 1. Analyse and interpret case history information and assessment data with support from the clinical educator. 2. Develop an appropriate therapy session plan for a patient taking into consideration the stated goals. 3. Conduct a motor speech treatment session clearly explaining therapy task requirements to the patient, appropriately adapting session requirements to reflect the patient's needs. 4. Write a complete progress note for a therapy session.
Debriefing model/s	Plus Delta or Pendleton

Discussion points

Please use these discussion points as a guide to the prebrief simulation 4 discussion:

- Important case data identified from the speech pathology rehabilitation file.
- TBI presentation – discussion regarding speech, language, high level language/cognitive communication skills.
- Patient journey and continuum of care: MVA – Intubated and airlifted – Treating medical team assigned – ICU – High Dependency Unit ward – Neurosurgery ward – Inpatient rehabilitation facility (BIRU) – Outpatient rehabilitation – Community.
- Glasgow Coma Scale (GCS).
- Typical speech pathology speech and language assessments used within TBI populations – Frenchay Dysarthria Assessment-2©, Mt Wilga High Level Language Test, Measure of Cognitive-Linguistic Abilities, Cognitive Linguistic Quick Test © (please include other examples to this list).
- Review the Frenchay Dysarthria Assessment-2© completed rating form and assessment manual.

Frenchay Dysarthria Assessment—Second Edition

FDA-2
Rating Form

Identifying Information

Last Name **GOODMAN**   D.O.B. _____
First Name **Michael**
Address **120 Mayfield Road**
Bankstown NSW 2200

Date _____
Hospital/Clinic **NSHS**

Influencing Factors

Check if contributing to speech disorder	✓
Hearing	
Sight	
Teeth	
Language	
Mood	
Posture	
Rate (Words/Min)	
Sensation	
Upper Lip (R)	
Upper Lip (L)	
Tongue Tip	
Subjective Report on Sensation	
Signed	*[signature]*

Chart (Normal Function → No Function, scale a–e):

Category	Task	Rating
Reflexes	Cough	c
	Swallow	b/c
	Dribble/Drool	b
Resp.	At Rest	b
	In Speech	c
Lips	At Rest	a
	Spread	b
	Seal	b
	Alternate	b/c
	In Speech	c
Palate	Fluids	b
	Maintenance	a
	In Speech	b
Laryngeal	Time	a
	Pitch	a/b
	Volume	b
	In Speech	c
Tongue	At Rest	c
	Protrusion	b
	Elevation	b
	Lateral	c
	Alternate	b
	In Speech	c
Intell.	Words	b
	Sentences	b
	Conversation	b

Summary

Moderate dysarthria characterised by impaired precision
and coordination of movements for speech and
impaired respiratory support for speech

Overall impact – ↓ articulatory precision, impaired ROS
and reduced volume. ↓naturalness &
intelligibility

Recommendations

1) 10 sessions speech therapy
targeting (•) artic. precision
(•) volume control
(•) prosodic elements
(•) rate of speech.

SPEECH PATHOLOGY – Progress and Assessment Report

PATIENT NAME: Michael Goodman
AGE: 26 years
GENDER: Male

ADDRESS: 120 Mayfield Road, Bankstown NSW 2200
PHONE: 0416 468 238
NEXT OF KIN: Mrs Pauline Goodman (mother) PH: 0423 165 239

BACKGROUND:

Michael is a 26 year old gentleman who suffered a traumatic brain injury (TBI) 6 months ago as a result of a single vehicle high speed motor vehicle accident. Emergency services attended the site of the accident. He had a GCS 3 at the scene. Michael was intubated and airlifted to the Intensive Care Unit (ICU) at the NSHS Hospital. Neuroimaging showed areas of petechial haemorrhage in subcortical white matter and thalami consistent with diffuse axonal injury. He was in an induced coma for 28 days in ICU. A tracheotomy was performed on Day 14. He was weaned from sedation and ventilation and, once medically stable, was transferred to the High Dependency Unit (HDU) of the acute neurosurgical unit where he remained for 2 months. He was weaned from the tracheostomy, successfully decannulated and recommenced oral intake during this time. He was then transferred to the Brain Injury and Rehabilitation Unit (BIRU) at NSHS. Following 3 months of inpatient rehabilitation, Michael was discharged. He is currently living with his parents.

On initial presentation to BIRU, Michael demonstrated bilateral hemiparesis (greater on the right than the left), ataxia, right sided intention tremor, dysphagia, dysarthria and a cognitive communication deficit. Michael is now walking with minimal supervision. He continues to require supervision to manage stairs. His gait is ataxic. He can independently complete personal ADLs. His right sided intention tremor has some impact on feeding himself and writing/using a keyboard.

Prior to his accident Michael was working for a property company in their marketing team. He had been with this company since graduating from university four years prior. He was living in an apartment with two friends (where he hopes to return to live in the future). He played soccer for a local team.

Michael has no significant medical history.

SPEECH AND LANGUAGE THERAPY HISTORY:

Michael was initially referred to speech pathology in ICU at the NSHS Hospital. He has continued to receive speech pathology management since this time for swallowing and communication. Most recently, while in BIRU, treatment has included intensive and

sessional programs targeting speech, high level language/cognitive communication deficits and swallowing difficulties. Michael's hearing has been assessed and is within normal limits.

Swallowing status/diet:
Michael has progressed onto a normal diet and thin fluids while an inpatient at BIRU. He experiences occasional coughing only on thin fluids. He uses a chin tuck technique when swallowing thin fluids to manage this. There are no current concerns regarding his chest condition.

Speech:
Michael's speech was assessed with the Frenchay Dysarthria Assessment – 2© FDA-2 edition on his admission to BIRU. At this time, he presented with a moderate-severe dysarthria with reduced intelligibility. He has received regular therapy primarily targeting articulatory precision and rate of speech to improve overall intelligibility.

Cognitive communication:
The Cognitive Linguistic Quick Test (CLQT)© was also administered on Michael's admission to BIRU. Results indicated mild impairments in the cognitive domains of working memory and executive functions. Michael has received regular therapy targeting these areas of deficit and was making good progress. It has been recommended (by the speech pathologist working with Michael in BIRU) that this type of therapy continue with a focus on tasks pertaining to his work.

Other interventions:
Michael has received both occupational therapy and physiotherapy during the acute and rehabilitation phases of his inpatient admission to the NSHS Hospital. He will continue with both occupational therapy and physiotherapy as an outpatient.

Current communication goals:
Michael's long-term goal is to return to work and to living in his apartment with his friends. He has been in contact with his workplace and they have offered him the opportunity to work a few hours a week with the support/supervision of his team and manager. Michael hopes that he will be able to build up his capacity to work more over time. He would like to improve his intelligibility when using the phone, and would like to speak with a greater degree of naturalness. He is aware that his voice is often quiet and that people often have difficulty understanding him because of this. He is also concerned about expressing himself and being understood in larger group conversations and the impact that this may have on him at work.

Michael reports some ongoing difficulties with verbal working memory and executive functions in more challenging tasks. He would like to focus on this in therapy within the context of work related activities in the lead up to his return to work.

ASSESSMENT RESULTS:

To assess progress and obtain a new baseline of speech functioning, Michael's speech was re-assessed with the FDA-2©. Results are as per below:

- Reflexes: Michael reports occasional coughing on thin fluids. He reported needing to take extra time when eating and drinking and using a chin tuck when drinking fluids (as previously recommended) to manage this.

- Respiration: Impaired respiration observed at rest. Michael demonstrated reduced respiratory control within speech with voice fading towards the end of sentences/utterances.

- Lips: Slight asymmetry at rest and during lip spread. Occasional air leakage from lip seal noted. Poor execution of alternate task i.e., 10 repetitions of "oo-ee". Movement was effortful and distorted production of target sounds.

- Palate: Slightly imbalanced nasal resonance noted. Nil other concerns.

- Laryngeal: Adequate length of phonation (i.e., able to say 'ah' clearly for 15 secs). Pitch was generally good with an occasional pitch break. Michael has minimal difficulty with volume task (counting from 1-5 with increasing intensity). Voice production in speech requires some effort. Volume deteriorates at times (particularly at the end of the utterance/sentence) which has some impact on intelligibility.

- Tongue: Overall, movements were slow and effortful. Particular difficulty noted on protrusion task and with alternating movements (saying ka-la 10 times). Difficulties were observed on isolated speech sounds and in speech and reduced intelligibility.

- Intelligibility: Michael presents with reduced intelligibility at word, sentence and conversation level. At conversation level, reduced intelligibility is only mild with occasional repetitions required to facilitate overall communication exchange.

SUMMARY:

Whilst Michael has shown significant improvements with his speech, repeat assessment indicates that he continues to present with a moderate dysarthria characterised by impaired precision and coordination of movements for speech and impaired respiratory support for speech. This results in overall reduced articulatory precision, impaired rate of speech and reduced volume contributing to a reduction in the naturalness and intelligibility of his conversational speech. Michael has identified speech deficits as an area that he would like to target.

Michael also presents with a mild cognitive communication impairment. He was making good progress with previously prescribed therapy activities targeting verbal working memory and executive functions. He would like to continue this with a focus on work related activities given his impending supported return to work.

RECOMMENDATIONS:

It is recommended that Michael attend a block of 10 therapy sessions targeting speech and cognitive communication impairments. Speech therapy should focus on overall articulatory precision for speech, volume control, prosodic elements and rate of speech. Cognitive communication therapy should target verbal working memory and executive functions within the context of work related tasks.

The results and recommendations have been discussed with Michael and he has agreed to the therapy.

If you have any further queries regarding this report, please contact the Speech Pathology community-based team on 1000 8729.

Katherine Spencer, SPEECH PATHOLOGIST
NSHS Speech Pathology Department – Brain Injury and Rehabilitation Team

cc: Speech Pathology patient file; Dr John Samuels (GP)

Debriefing Simulation 4

Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
After participation in this clinical simulation, students will be able to: 1. Analyse and interpret case history information and assessment data with support from the clinical educator. 2. Develop an appropriate therapy session plan for a patient taking into consideration the stated goals. 3. Conduct a motor speech treatment session clearly explaining therapy task requirements to the patient, appropriately adapting session requirements to reflect the patient's needs. 4. Write a complete progress note for a therapy session.	**Plus Delta** **Plus** defines **what is going well**. **Delta** defines what needs changing to **improve learning**	**Thinking about that simulation:** • What went well in that simulation? • What did you observe in others that worked well in that simulation? • What do you think you need to change to improve your learning? (as a group or individually)	
		OR	
	Pendleton Focusses on the **learner self-evaluating** before the facilitator provides feedback. Focusses on **positive aspects** before those aspects which require development.	**Thinking about that simulation:** • How did you feel in that session? • Tell me what you think went well? • Why do you think this went well? • I think that you went well in ……………, when you ………… (might do this as a group or pointing out specific observations of individuals) • I think this was because you were able to………. because I observed you	

Debriefing Simulation 4

Intended learning outcomes	Debriefing tool	Clinical educator prompts	Feedback / notes
		…………. (be specific in situation observations). • I wonder what you feel you could have done a little better. What do you think? (might do this as a group or pointing out specific observations of individuals). • Why do you think this was the case? • I think that you could have …….. because I observed that you didn't…….. (make specific suggestions for reasons). • I wonder if you could improve in this by ……. (name suggestions for change). • Overall, I think you were strong in the areas of ………… (up to 3 areas of strength) and I think it would be great if you could focus on improvement in ………. (up to 3 areas for improvement). • Let's review your progress in the next simulations.	

Clinical educator self-evaluation at conclusion of simulation

1. What worked well with this simulation?
2. What didn't work well with this simulation?
3. How was the timing for this simulation?
4. What would you do differently next time?