Simulation-based Learning Program

Student workbook: Day 1

Developed as part of the *Embedding Simulation in Clinical Training in Speech Pathology* project 2014 – 2018

Citation/attribution format:

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Contents

Day 1 timetable - overview

Day 1	
10:00am	Introduction to simulation
	Simulation Program orientation/start of placement
11:30am	LUNCH
12:15pm	**Simulation 1:** Mr Tom Jones (clinical educator led)
1:45pm	**Simulation 2:** Mr Tom Jones (student led)
3:40pm	Simulated patient feedback
4:00pm	Preparation for Day 2
4:30pm	Close of Day 1

Part one: What is simulation and background to simulation

Simulation is a means to replicate a clinical experience (Ker & Bradley, 2014). The fidelity of a simulation scenario is maintained when a participant engages in and thus responds affectively and cognitively to the simulated learning environment in a similar manner to that of a traditional clinical placement (Ker & Bradley, 2014). The inclusion of simulation in the training of students in medical, nursing and other allied health professions has been found to be viable. For example, simulation has been documented in the training of medical students for over forty years with positive results (Barrows, 1971). However, research related to its use in speech pathology clinical practice has been more limited (Hill et al., 2010, 2013a,b; MacBean et al., 2013; Ward et al., 2014, 2015). Embedding simulation in speech pathology has therefore been a priority for further investigation.

A number of health professions have acknowledged the importance of embedding simulation as an alternative and complementary training method for students and have reported that it is an effective means of reducing the demand for clinical placement days whilst still ensuring optimal clinical skill development of each student. Hayden et al. (2014) conducted a multi-site study in 10 nursing programs across the United States and found no statistically significant differences in knowledge, clinical competency, critical thinking and readiness for practice for students undertaking traditional placements versus students substituting 25% and 50% of clinical placement time with simulation.

Similarly, studies within physiotherapy have determined that a proportion of traditional clinical time could be replaced by simulation experiences without undermining students' development of knowledge and skills (Blackstock et al., 2013; Watson et al., 2012). For example, Watson et al. (2012) investigated student outcomes when 25% of clinical placement time was replaced by simulation in a musculoskeletal physiotherapy program. Outcomes of this study indicated that there were no differences in student outcomes and students' perceptions of their skills when simulation replaced a portion of traditional clinical time.

Published studies related to simulation-based learning in speech pathology have focussed primarily on issues related to perceptions, reflections and preferences (e.g. Hill et al., 2013a,b,c; Ward et al., 2015). For example, Hill et al. (2013a) reported that standardised patients were accurately able to replicate a clinical scenario for students to engage in clinical skill development. Additionally, research found that speech pathology students' perceptions of standardised patient clinics were positive (Hill et al., 2013b). Ward et al. (2014) successfully used high fidelity mannequin based simulation scenarios to train inexperienced speech pathology clinicians in more specialist areas. The results revealed that clinicians not only were able to acquire improved manual skills and core task performance skills but also developed increased confidence levels. There have been no studies within speech pathology to date which have focussed on students' development of clinical competency within a simulation-based environment. The outcomes of studies within nursing and

physiotherapy served as an impetus to determine whether simulation-based learning experiences in speech pathology in combination with traditional clinical placements would offer the same learning and competency outcomes when compared with traditional clinical placement experiences.

The *"Embedding Simulation in Clinical Training in Speech Pathology"* project was initiated by Heath Workforce Australia in 2010, as part of a review of the use of simulation in many allied health professions. In the feasibility study in 2010, a collaborative of universities investigated current and planned practices in simulation within speech pathology training programs and concluded that use of simulation-based learning in clinical education had the potential to assist educators to meet placement demand, and that it may in fact result in superior learning outcomes for students in areas such as development of clinical reasoning skills and working with other professions (MacBean et al., 2013). The collaborative was committed to the development and integration of simulation-based learning into clinical education curricula and to building an evidence base that evaluated its use.

National speech pathology simulation project 2014-2018:

In 2014, Health Workforce Australia provided funding to Speech Pathology Australia to undertake Phase 1 of the *"Embedding Simulation in Clinical Training in Speech Pathology"* project. A collaborative of six universities across Australia was awarded this funding to develop a plan to investigate whether simulation could replace a proportion of clinical placements without loss of clinical competency. The Phase 1 project plan was completed in October 2014 and the collaborative was awarded further funding in December 2014 to conduct a randomised controlled trial. Phase 2 of the project commenced in May 2015 and was completed in November 2018. Health Workforce Australia was disbanded in August 2014 and current funding was then provided by the Department of Health (Commonwealth).

The overall aim of the *"Embedding Simulation in Clinical Training in Speech Pathology"* project was to determine if students in accredited speech pathology programs achieved a comparable level of competency (i.e., performance in the same Zone of Competency on COMPASS®) in middle-level placements involving the management of adult patients, if they either:-
  (a) completed a clinical placement where an average of 20% of the traditional clinical placement time is replaced with a simulation model, or
  (b) completed a traditional clinical placement for 100% of the time.

Further information about the *"Embedding Simulation in Clinical Training in Speech Pathology"* project, including outcomes of the research study, can be obtained through contacting the project leader, Dr Anne Hill (ae.hill@uq.edu.au).

Overview of the Simulation-based Learning Program

Process of learning

All activities within the simulated learning program are designed to assist student learning. Each simulation consists of the following learning cycle:

  1. **Pre simulation activities and prebriefing**: The student group will be briefed by the clinical educator and will have the opportunity to review documentation related to the upcoming simulation and to discuss this with the clinical educator and peers. Workbook activities will be completed in small groups to guide this discussion before the simulation commences.
  2. **Simulation**: Students will enter a simulation and work in pairs or simulation units, with each student having an opportunity to play the role of the speech pathology clinician. A time

in/time out approach may be used during the simulation to provide online feedback and to facilitate each student taking a turn in role.

3. **Post simulation activities and debriefing:** The student group will engage in a debrief with the clinical educator. Students will have the opportunity to provide feedback to peers and to complete the related post-simulation activities in their workbook. Simulated patients will provide feedback to students following some of the simulations.

Simulation ground rules

- Professionalism is expected at all times, with respect to punctuality, dress, manner, provision of feedback, and engagement with staff and simulated patients.
- Confidentiality is expected at all times with respect to client data used within simulations.
- Confidentiality is expected with respect to the Simulation-based Learning Program activities and process of learning.
- Students are expected to engage with colleagues and clinical educators to gain the most from this learning experience.
- Feedback will be provided across the week from a range of sources (see below). Students are expected to fully engage in the feedback process to maximise learning outcomes.

Feedback during the Simulation-based Learning Program:

- ### Feedback during patient interaction

Some feedback provided to students will occur during normal clinical interactions with their peers in role play or in interactions with simulated patients. This will mirror usual practice in clinical placements. This feedback is generally directed at the student directly involved in the interaction and is usually quick and does not interrupt the clinical interaction. It is feedback 'on the go'.

- ### Pause-discuss feedback method

This feedback occurs with interruption to the student-patient interaction process and is usually conducted where there is more than one student involved in the simulation. The simulated patient stays in role and the students and clinical educator have the opportunity to briefly discuss what they observed. This pause-discuss model is useful to guide students through assessment and management processes, discuss clinical reasoning around client presentation and to support students in their development of skills through immediate feedback (Ward et al., 2015).

The pause-discuss model can work in two ways:

1. The student seeks the clinical educator's assistance within the simulation to discuss their action, ask a brief question or obtain guidance about their decisions. The simulation continues while this brief discussion with the student occurs i.e., the clinical educator involves the simulated patient in their discussion with the student.
2. The 'time in, time out' technique (e.g., Edwards & Rose, 2008). The clinical educator determines that a break in the simulation is required in order to more extensively discuss the progress of the interaction and to engage the observing students in this discussion. The simulation is paused and a 'time out' is called. A pause occurs and discussion follows with the educator and all students. During this discussion, the group may focus on what they observed, their clinical reasoning about

the client's presentation, and the next steps in the process. They may also discuss the student's performance and make constructive comments on changes which may be made. This method is also effective in highlighting positive performance from students and using this as a model for further performance. 'Time in' is then called and the student repeats the interaction OR the next student takes a turn in the assessment or intervention process. The cycle of pause and discuss continues.

General guidelines for students when providing feedback to peers within simulation: *(based on Hattie & Timperley, 2007; McAllister & Lincoln, 2004)*

- Be sure that before giving feedback to your peer, he/she has had the opportunity to discuss his/her performance and feelings about it.
- Give solicited feedback (i.e., feedback asked for by your peer) rather than focusing on what you see as being important. Remember feedback should be for the benefit of the receiver.
- Be sure to give feedback on the person's strengths as well as their weaknesses and things that could be improved.
- Give 'appropriate' feedback, that is, feedback about behaviour that CAN be changed – feedback that can be used in a constructive way. It is important that your peer can take away ideas about an area he/she can positively work on.
- Give specific feedback that describes an area you have observed. For example, *"you were just the right distance away from your client but you didn't look at him very often".*
- Do not be judgmental – feedback should not focus on the other's values, beliefs, personality traits.
- Avoid the use of clinical terms or labels – use language which is understood readily by both parties.
- Focus on the impact that your peer's verbal or nonverbal behaviour may have had on another person (client, peer, clinical educator).
- Be clear, precise and specific in your feedback. For example, *"I liked the way you _____",* *"The way you _____ was excellent".*
- Avoid giving too much feedback at one time. Encourage your peer to comment or engage in brief discussion on your feedback in one area before moving on to another area.
- Check that your peer is in agreement with your perceptions of a session e.g., *"does that fit with the way you see things?"* Be flexible enough to change your perceptions if need be.

General guidelines for students when receiving feedback within simulation

- Listen carefully to the entire feedback given. A good way of ensuring that you have correctly heard and that you understand the feedback is to check your perceptions of the feedback. *"If I understand, what you're saying is…..".*
- Remember that all feedback is based on what the observer perceives and feels about the situation.
- You should give as much attention to the positive feedback which is given to you as you do to the critical feedback.
- It is sometimes difficult to respond immediately to feedback. It is not expected that you respond completely and immediately to all that is said to you. However, it is important that you acknowledge the feedback and provide some comment if you can.
- If the feedback given to you has not covered all questions you had, you should feel free to ask for further feedback in other areas.
- Ask if necessary for clarification and elaboration from the person giving you feedback.

Orientation to National Simulation Health Service (NSHS)

- Tertiary health care centre providing care in most major adult specialities.
- Services provided: acute medical, surgical, cancer, rehabilitation and allied health services.
- Overview of core speech pathology caseloads: stroke, neurology, neurosurgery, general medical, general surgical, inpatient and outpatient geriatric rehabilitation, inpatient and outpatient brain injury rehabilitation.
- OH&S procedures (practical) – hand washing, safety.
- Administrative procedures – confidentiality procedures, statistics, documentation (progress note examples, templates).

Simulation-based Learning Program timetable

Day 1	
10:00am	Introduction to simulation Simulation Program orientation/start of placement
11:30am	LUNCH
12:15pm	**Simulation 1:** Mr Tom Jones (clinical educator led)
1:45pm	**Simulation 2:** Mr Tom Jones (student led)
3:40pm	Simulated patient feedback
4:00pm	Preparation for Day 2
4:30pm	Close of Day 1

Day 2	
8:30am	General preparation time
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 3	
8:30am	General preparation time
9:00am	**Simulation 5:** Mrs Margaret Henderson (swallowing assessment)
11:45pm	LUNCH
12:30pm	**Simulation 6:** Mrs Margaret Henderson (communication assessment)
3:00pm	Afternoon tea
3:15pm	Progress note writing
3:45pm	Preparation for Day 4
4:30pm	Close of Day 3

Day 4	
8:30am	Stop-Keep-Start debrief
8:45am	General preparation time
9:15am	**Simulation 7:** Mrs Beth O'Connor
	Simulation 8: Mr Jim Parker
	Simulation 9: Mr Selwyn Walker
	Simulation 10: Ms Emily Gleeson
12:00pm	LUNCH
12:45pm	**Simulation 11:** Mrs Margaret Henderson (therapy session)
3:00pm	Simulated patient feedback
3:15pm	Afternoon tea
3:30pm	**Prebrief Simulation 12:** Mr James (Jim) Parker - Review videofluroscopy
4:30pm	Preparation for Day 5
5:00pm	Close of Day 4

Day 5	
8:30am	Stop-Start-Keep debrief
8:45am	General preparation time
9:00am	**Simulation 12:** Mr James (Jim) Parker + Betty Parker
10:15am	**Simulation 13:** Speech pathology case handover
11:30am	**Debrief simulations 12 + 13** *Simulated patient feedback*
12:30pm	End of Simulation Program activities
1:30pm	Close of Day 5

References

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Blackstock, F.C., et al. (2013). Simulation can contribute a part of cardiorespiratory physiotherapy clinical education. *Simulation in Healthcare, 8*(1), 32-42.

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SIMULATION ONE - Mr Tom Jones (Clinical educator led):

Mr Tom Jones is a 65 year old gentleman from Newtown who suffered a left hemisphere stroke three weeks ago.

SIMULATION DETAILS:

Your clinical educator will conduct a session with Tom to:
1. Discuss the assessment results with Tom.
2. Develop appropriate treatment goals.
3. Provide education regarding aphasia.
4. Provide an example of a convergent naming therapy task.

You will observe your clinical educator (from within the session) and complete a structured observation of the session for discussion (see page 9).

The simulation will consist of three parts. All parts will be led by your clinical educator:
1. Prebrief (refer to pre simulation activities below).
2. Simulation.
3. Debrief.

INTENDED LEARNING OUTCOMES:

After participating in the structured observation of a clinical educator-led rehabilitation session, you will be able to:
1. Interpret medical chart information and identify relevant data for a patient.
2. Identify professional competencies demonstrated by the clinical educator that led to an effective rehabilitation session.
3. Identify the strategies used to communicate effectively the results of a formal language assessment to a patient who has recently acquired a communication disorder.
4. Explain the concept of patient-centred practice and collaborative goal-setting and their contribution to patient outcomes.

SETTING:

NSHS Rehabilitation Unit
Speech pathology treatment room

RESOURCES PROVIDED:

1. Patient speech pathology file with completed Western Aphasia Battery – Revised (WAB-R)©, record form.
2. This booklet.

1. Read the patient's medical chart and, together with your clinical educator, complete the table below.

Name:	Gender:
Age:	Occupation:
Reason for admission:	
Investigations (Ix):	
Diagnosis (Dx):	
Past medical history (PMHx):	
Medications (Rx):	
Social history (SHx):	
Clinical pathway:	

2. What information is important for you to consider from the medical chart before you observe this patient for their first treatment session in the rehabilitation setting? (e.g. what may impact your session? What information may you be able to use in your session when talking to Tom).

3. Review the Western Aphasia Battery - Revised (WAB-R)© assessment results with your clinical educator. Summarise key points below.

WAB-R© subtest	Score	Comments about performance
Spontaneous speech • Conversational questions • Picture description		
Auditory verbal comprehension • Yes/No Questions • Auditory word Recognition • Sequential commands		
Repetition		
Naming and word finding • Object naming • Word fluency • Sentence completion • Responsive speech		

Western Aphasia Battery-R © Aphasia Quotient (AQ) score	Severity level
0 – 25	Very severe
26 – 50	Severe
51 – 75	Moderate
76 and above	Mild

4. How might your clinical educator need to modify their questions and interactions given the patient's presentation?

You will now enter the simulation and observe the session with Tom.

With respect to the session goals on pages 13 and 14, record your observations of <u>your clinical educator's</u> communication and interaction with the patient:

Session Goals	Observations
Introduction • Introducing self • Explaining role of speech pathology • Outlining session goals	
Rapport building • Language use • Verbal communication skills • Nonverbal communication skills	
Explanation of assessment results • Language use – any use of jargon? • Level of detail • Information provided to aid understanding	
Discussion of goals • Prompt questions used • Prioritisation of goals	
Explanation and demonstration of therapy tasks • Language use • Level of detail • Information provided to aid understanding • Cueing hierarchy used	
Plan for further therapy • Summary of the session	

Notes from Simulation 1:

References/ recommended reading

1. Stroke Foundation (2018). *Clinical Guidelines for Stroke management 2017.* Retrieved 18 June 2018, from https://informe.org.au.
2. Murray, L. L., & Clark, H. M. (2006). *Neurogenic Disorders of Language: Theory Driven Clinical Practice.* Clifton Park, NY: Thomson Delmar Learning.
3. Australian Aphasia pathway: Best Practice for Aphasia across the Continuum of Care. (2014). www.aphasiapathway.com.au.
4. Kertesz, A. (2006). *Western Aphasia Battery – Revised*. San Antonio, TX: Pearson.

SIMULATION TWO - Mr Tom Jones (student led):

Mr Tom Jones is a 65 year old gentleman from Newtown who suffered a left hemisphere stroke three weeks ago.

SIMULATION DETAILS:

You and your partner will conduct a session with Tom.

In this session you will be required to:
1. Discuss the assessment results with Tom.
2. Develop appropriate treatment goals.
3. Provide education regarding aphasia.
4. Discuss possible treatment activities that Tom can expect to do whilst he is in rehabilitation.

You will have **15 minutes** to conduct this session with Tom.

When not conducting your session, you will be asked to observe another session and complete a structured observation (see below).

The simulation will consist of three parts. All parts will be led by your clinical educator:
1. Prebrief (refer to pre simulation activities below).
2. Simulation.
3. Debrief.

INTENDED LEARNING OUTCOMES:

After participation in this clinical simulation, you will be able to:
1. Effectively communicate the results of a formal language assessment to a patient who has recently acquired a communication disorder.
2. Set goals collaboratively with the patient.
3. Provide education regarding aphasia.
4. Effectively implement relevant impairment-based language therapy tasks.

SETTING:

NSHS Rehabilitation Unit
Speech pathology treatment room

RESOURCES PROVIDED:

1. Patient speech pathology file with completed Western Aphasia Battery – Revised (WAB-R)©, record form.
2. Paper to document goals with patient.
3. Therapy resources (located at the back of this booklet).

1. Review the completed session plan (over page) for your session in Simulation 2 with your pair and determine who will lead each of the session goals.

You will now enter the simulation and conduct/observe the session with Tom

Therapy session plan

Patient Name: Tom Jones

- **Long term goal(s):** To be determined during the session.
- **Short term goal(s):** To be determined during the session.

Session element	Goal / Activity	Time	Materials	Criterion	Theoretical basis & rationale
1. Introduction / Rapport Building	• Clinician to introduce self and explain role of speech pathology in Tom's rehabilitation. • Clinician to provide outline of session and explain session goals. • Clinician to engage Tom in conversation to assist development of rapport and solid foundation for an effective working relationship.		Nil	N/A	• It is important for Tom to understand the role of speech pathology in his intervention and to be aware of session goals in order to appropriately participate in the session. • Rapport building allows the patient to feel more at ease during a session and may improve patient-clinician interactions and collaborations.
2. Explanation / Discussion of WAB-R results	• Clinician to discuss results of formal language assessment (Western Aphasia Battery – Revised (WAB-R©) with Tom. • Clinician to identify Tom' strengths and areas of need with Tom and discuss impacts of these. • Clinician to ensure Tom has an adequate understanding of results and should clarify any points as necessary.		WAB-R© assessment record form	N/A	• Review of assessment results and identification of strengths/weaknesses with patients is important to increase self-awareness and assist in goal setting.
3. Goal setting	• Clinician to discuss importance of goals in rehabilitation and collaborate with Tom to develop a set of goals to target within speech therapy sessions. • Clinician to ask prompting questions to determine Tom's current areas of concern and to assist Tom to consider all areas of		Paper / Pens	N/A	• To ensure patient-centred therapy, collaboration between patient and clinician is fundamental. Clinicians should scaffold discussions to appropriately identify patient concerns and goals for therapy. • Clinicians should use evidence-based

Session element	Goal / Activity	Time	Materials	Criterion	Theoretical basis & rationale
	communication that may require additional therapy. • Clinician and Tom should develop 1x LTG and 2 STGs.				practice principles in development of therapy goals and in therapy planning. • LTG = long term goal (where should patient be ideally, when finished all therapy for current concerns). • STG = short term goals (2-3 shorter term goals that may be achieved during inpatient rehabilitation).
4. Provide education regarding aphasia	• Clinician to provide education regarding aphasia to Tom.		Poster	N/A	• To ensure patient-centred therapy, it is important for the person with aphasia to be educated regarding aphasia.
5. Explanation / demonstration of therapy tasks	• Clinician to explain and demonstrate an impairment based semantic therapy activity that Tom may complete in therapy (convergent naming task). • Clinician to explain the purpose of semantic therapy tasks and assists Tom to complete 3-5 trial items.		Convergent Naming worksheet Cueing hierarchy *Resources at back of booklet.*	N/A	• Explanation and demonstration of therapy tasks in initial session will assist patient to: • Gain a clear understanding of how speech therapy activities may target identified weaknesses / therapy goals.
6. Question time, wrap-up & plan.	• Clinician to invite Tom to ask any questions and should clarify any concerns. • Clinician to conclude session by outlining future plans as decided in therapy. • Clinician to explain to Tom that they will meet for regular therapy to target the goals identified during today's session.		Nil	N/A	• Providing time for patient to ask any questions is important for ensuring their understanding and increasing compliance. • Important to provide patient with follow-up plan and ensure both patient and clinician are 'on the same page'.

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

Record your observations of <u>one student pair's</u> communication and interaction with the patient, using the structured observation guide below.

Session Goals	Observations
Introduction • Introducing self • Explaining role of speech pathology • Outlining session goals	
Rapport building • Language use • Verbal communication skills • Nonverbal communication skills	
Explanation of assessment results • Language use – any use of jargon? • Level of detail • Information provided to aid understanding	
Discussion of goals • Prompt questions used • Prioritisation of goals	
Explanation and demonstration of therapy tasks • Language use • Level of detail • Information provided to aid understanding • Cueing hierarchy used	
Plan for further therapy • Summary of the session	

Post simulation activity

The following is an example of speech pathology progress note for a medical chart. You can use this as a guide when writing future progress notes.

DD/MM/YY 00:00	**SPEECH PATHOLOGY:** SP student clinicians met with pt today to discuss results of WAB-R, provide education and discuss goals for future therapy.
	O/E: Pt seen in SP rehabilitation clinic room. Consent obtained for session. Pt was motivated and engaged throughout the session. Pt demonstrated adequate insight and awareness of his WFDs. WAB-R Ax results discussed with pt with identification of strengths and weaknesses. In collaboration with the student clinicians the pt was able to develop the following goals for therapy:- 1. To be able to communicate effectively with His family members 2. To be able to return to work and liaise with clients as required. 3.Improve overall word retrieval and fluency.
	Aphasia Dx was discussed with pt and education provided.
	SUMMARY: Pt presents with mild receptive aphasia and mild-moderate expressive aphasia characterised by word finding difficulties affecting spontaneous and conversational speech. Receptive difficulties noted with increased complexity of commands/instructions.
	RECOMMENDATIONS: Pt would benefit from daily therapy to targeting word retrieval and production and higher level receptive abilities.
	PLAN: 1. Liaise with MDT re: language difficulties.
	2. Contact wife (pt consent provided) to attend next therapy session to review Dx, provide education and discuss goal setting.
	3. Further assessment ?PALPA to further determine level of breakdown.
	(S.PERKINS) SPEECH PATHOLOGIST (Pager #352) ---------------------------

Reflection task:

Following the debrief for this simulation, consider some of the important information or feedback you received or gained from this simulation (from your clinical educator, simulated patient and peers). Space to record this information has been provided below.

Notes from Simulation 2:

References/ recommended reading

1. Stroke Foundation (2018). *Clinical Guidelines for Stroke management 2017.* Retrieved 18 June 2018, from https://informe.org.au.
2. Murray, L. L., & Clark, H. M. (2006). *Neurogenic Disorders of Language: Theory Driven Clinical Practice.* Clifton Park, NY: Thomson Delmar Learning.
3. Australian Aphasia pathway: Best Practice for Aphasia across the Continuum of Care. (2014). www.aphasiapathway.com.au.
4. Kertesz, A. (2006). *Western Aphasia Battery – Revised.* San Antonio, TX: Pearson.

DAY 1 STATISTICS RECORD

Date	PATIENT NAME and UR	Time spent on Patient-Related Tasks (Please round to nearest ¼ hour)		
		Preparation	Direct Contact (i.e. Ax or Tx)	Documentation

THERAPY RESOURCES

DAY 1

SIMULATIONS 1 and 2

Spoken Naming Cueing Hierachy (Cardell and Lawrie, 2012)

Clinician's Cueing Hierachy:

Note: Encourage the individual to silently rehearse each word 'in their head' before saying the word aloud to optimise the retrieval of the correct phonological form.

Target = 'bed'

1. **Phonemic cue (PC)**	It starts with a 'b'.
2. **Semantic cue (SC)**	You sleep in it.
3. **Sentence completion cue (Sent)**	You sleep in a _____ .
4. **Sentence completion and phonemic cue (Sent & PC)**	You sleep in a b_____ .
5. **Anagram using letter tiles (An)**	
6. **Written word cue/arrange letter tiles (W)**	
7. **Written word cue and phonemic cue (WC &PC)**	
8. **Repetition (Rep)**	

Note: The above hierarchy is not 'set in cement'. Use your clinical judgement to modify the hierarchy of cues, according to the client's individual processing profile.

Convergent naming task (therapist/student copy)

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. Its 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. (book)

10. It falls from the sky and is wet. (rain or snow)

Convergent naming task

Target: Word retrieval; semantics

Instructions: Name the object which is being described.

1. It swims in the ocean. You can eat it. _____

2. It is a yellow and green vegetable. It comes on a cob. _____

3. It shines in the night sky. There are many of them. _____

4. You put a key into it to open it. _____

5. It's an animal. Its coat is made of wool. _____

6. Looks after patients in a hospital. Works with doctors. _____

7. You use it to clean your teeth. You put toothpaste on it. _____

8. A body part attached to your leg that you walk on. _____

9. You read it. It can be delivered daily to your house. _____

10. It falls from the sky and is wet. _____