Oxford University Hospitals
NHS Foundation Trust

Acute Adult Speech and Language Therapy

Clinical Placement

Student Information Pack 2021/2022

PLEASE NOTE THAT THERE MAY BE MODIFICATIONS TO CLINICAL PLACEMENTS DURING THE COVID-19 PANDEMIC IN LINE WITH OUH TRUST AND NATIONAL POLICY. INDIVIDUAL STUDENTS WILL BE CONTACTED BY THEIR DESGINATED PLACEMENT EDUCATOR TO DISCUSS EACH PLACEMENT BEFORE THEIR START DATE

CONTENTS

Departmental Information:

NEUROSCIENCES DEPARTMENT, L2 WEST WING, JOHN RADCLIFFE HOSPITAL

The S&LT Neurosciences Department is made up of a Highly Specialist Neurosciences Speech and Language Therapist and a Specialist Neurosciences Speech & Language Therapist forming 1.0wte.

Claire McMahon (Highly Specialist SLT-Neurosciences) works Monday and Tuesday.

Daniela Carrasco (Specialist SLT Neurosciences) works Tuesday – Friday (9.30am – 2.30pm).

Our office is based in the Neurosciences Rehabilitation Department on Level 2 of the West Wing at the John Radcliffe Hospital and our direct line is 01865 231714. We can also be contacted via e-mail –
Claire.Mcmahon@ouh.nhs.uk and Daniela.Carrasco@ouh.nhs.uk

This placement may not be suitable for students with mobility issues, students are likely to be mobile, spending much of the day standing at bedside and walking between patient bed spaces across three floors. Lifts are available. A car is not essential.

We offer an inpatient service to the Neurosciences ward and Neuro Intensive Care (NICU). The main ward is occupied by patients who have a range of neuro-medical and neurosurgical conditions (54 beds). We also have a high dependency unit (8 beds) providing a step down from NICU. Neuro Intensive Care is a separate 16 bedded ward. We also provide a service to the Neuro-Investigation ward, which is a 12 bedded day ward.

In addition, we also provide input to SSIP ward (specialist surgery inpatients). This includes patients who have had plastics or ENT surgery input.

1. **Neuromedical beds**
   Patients may have neurological conditions such as Parkinson ’s disease, MND, Myasthenia Gravis, Lambert-Eaton Syndrome, Guillain-Barre Syndrome, Miller Fisher Syndrome, Multiple Sclerosis, Multiple Systems Atrophy, Dermatomyositis, Encephalitis, CVA, and Lateral Medullary Syndrome.

2. **Neurosurgical beds**
   Patients may have conditions such as cerebral tumours, aneurysms, acoustic neuromas, head injuries, subarachnoid haemorrhage, and subdural haematoma. These patients may have had surgical procedures, such as debulking of a tumour, ventricular drainage, coiling or clipping of an aneurysm, embolisation, and craniotomy.

3. **Neuro-Intensive Care Unit (NICU)**.
   Patients on this ward may present with any of the above conditions and are acutely unwell. Often they will be on assisted ventilation and may have a tracheostomy.

SUMMARY OF CONDITIONS / DISORDERS

The following summarises the neurology of the more common disorders that you may see whilst on placement. You may want to familiarise yourself with the speech, language and swallowing aspects of some of these disorders.

Neuromedical

Myasthenia Gravis is the most common primary disorder of neuromuscular transmission. The usual cause is an acquired immunological abnormality, but some cases result from genetic abnormalities in the Neuromuscular Junction (NMJ). In MG, the neurotransmitter Acetylcholine (the chemical that transmits impulses between nerves and muscles) is blocked by antibodies to its receptor. Patients present with limb weakness, ptosis or diplopia, aphonia, dysarthria and dysphagia. Symptoms become worse with prolonged muscle movement.

Lambert-Eaton Syndrome (myasthenic syndrome) is a disorder with symptoms very similar to those of Myasthenia Gravis. There is muscle weakness associated with disturbed communication between nerves and muscles. In Lambert-Eaton Syndrome, the distortion is caused by an insufficient release of neurotransmitter by the nerve cell. As muscle contraction continues, the amount of neurotransmitter may build up in sufficient quantities and result in increased strength. Therefore, clinically, MG results in weaker muscle movement with continued use, and LEMS in stronger muscle movement.

Multiple Sclerosis – The central nervous system becomes inflamed and destroyed by the patient's own immune system in a process called demyelination, which usually starts in adult life. There are three different patterns: relapsing/remitting MS (80% show this pattern), secondary progressive MS (follows on from the relapsing/remitting type in 50% of cases within 10 years. Recovery from relapses is incomplete, and the relapsing pattern is progressively lost.) Primary progressive MS occurs in 10-15% of patients. Symptoms do not remit and progressively worsen with time from the onset of the condition. Symptoms include pain, fatigue, bowel and bladder problems, spasticity, depression (36%), anxiety (25%). We are asked to see MS patients with speech and swallowing problems, but have also encountered language disorders in this client group.

Gullian-Barre Syndrome is an acute inflammatory demyelinating disorder that affects the peripheral nerves, sympathetic and parasympathetic nerves. 50-70% of GBS patients have had a recent viral or bacterial infection. It is an auto-immune disease. That is, the body's own immune system begins to attack the body itself. In GBS, motor weakness of more than one limb occurs progressively over days to six weeks. Recovery takes weeks to months. Miller Fisher Syndrome is a variant of GBS, and is characterised by abnormal muscle coordination (ataxia), opthalmoplegia (paralysis of eye muscles) and absence of reflexes.

Motor Neurone Disease is a progressive condition characterised by degeneration of motor neurones in the cortex and the anterior horns of the spinal cord, and degeneration of cranial nerve nuclei within the brainstem. Sensation is preserved in people with MND. Different terms are often used to describe involvement at each level of the CNS .

- **Amyotrophic Lateral Sclerosis** (ALS) accounts for 66% of cases, and is a mixture of both upper and lower motor neurone involvement. It is characterised by muscle weakness, spasticity, hyperactive reflexes and emotional liability.
- **Progressive Bulbar Palsy** (PBP) (25% of cases) degenerates the nerves that control speech and swallowing.

- **Progressive Muscular Atrophy** (PMA) affects mainly the lower motor neurones, and is characterised by muscle wasting and weakness, loss of weight and muscle twitching.
- **Primary Lateral Sclerosis** (PLS) affects primarily the upper motor neurones, resulting in stiffness and spastic paralysis of the limbs.

Parkinson's Disease occurs when certain nerve cells in the part of the brain called the substantia nigra die or become impaired. Normally, these cells produce a vital chemical known as dopamine. Dopamine allows smooth function of the body's muscles and movement. The loss of dopamine production in the brain causes the primary symptoms of the disease. These are tremor, slowness of movement (bradykinesia), rigidity, and difficulty with balance. They present with hypokinetic dysarthria and dysphagia.

Multiple Systems Atrophy refers to three slowly progressive related disorders that affect the central and autonomic nervous system. There is a life expectancy of 10 years or less, and it is usually diagnosed in people over 50. *Olivopontocerebellar atrophy* affects balance, coordination and speech. *Striatonigrad degeneration* is a parkinsonian form, characterised by slow movement and stiff muscles. *MSA with orthostatic hypertension* (formerly Shy-Drager syndrome)is a form with predominant autonomic system involvement. In all three forms of MSA, the patient can have orthostatic or postural hypotension (an excessive drop in blood pressure when the patient stands up, causing dizziness or momentary blackouts). Other symptoms include stiffness, rigidity, loss of balance/coordination, impaired speech, breathing and swallowing problems, blurred vision, impotence, constipation and urinary difficulties. Most patients develop dementia in the late stages of the disease. There is no specific treatment.
(National Institute of Neurological Disorders and Stroke)

Dermatomyositis is thought to be an autoimmune disease, meaning that the body's immune system, which normally fights infections and viruses, does not stop fighting once the infection has gone. It is more common in women, and can occur at any age. It presents as a rash which looks patchy, reddish or purple. Some people also have hardened bumps under the skin. Muscle weakness usually happens over a period of days, and begins with muscles that are closest to and within the trunk of the body, e.g. neck, hip, shoulders. Some DM patients have dysphagia. Patients are treated with Prednisone, which is a steroid, to stop the body from attacking the muscles by slowing down the immune system.
(The Myositis Association website)

Acoustic Neuromas are benign tumours of the 8th cranial nerve. Symptoms include hearing loss, tinnitus and imbalance. Treatment is either microsurgery aimed at complete removal of the tumour, or Gamma knife surgery, a radiosurgery technique to shrink the tumour over time. Microsurgery may result in hearing loss on the affected side, and 1 in 5 patients may suffer facial nerve damage, resulting in facial palsy. Whereas over 90% of patients who have Gamma knife surgery have no hearing loss or facial weakness.
(British Association Acoustic Neuroma – BANA)

Encephalitis means inflammation of the brain. It can occur at any age, and is usually the result of a viral infection. There are two types of encephalitis – one is *Acute Viral Encephalitis* caused by a direct viral attack on the brain, and the other is *Post Infectious Encephalitis,* an auto-immune condition whereby the body's immune system attacks the brain following an infection somewhere else in the body. Range of symptoms vary widely and include confusion, drowsiness, fits, coma, aversion to bright lights, inability to speak, personality changes, hallucinations and disorientation.

Lateral Medullary Syndrome (Wallenberg Syndrome) is a neurological disorder characterised by swallowing difficulties and hoarseness, which results from paralysis of a portion of the vocal folds. The paralysis is caused by a blockage in a cerebral or cerebellar artery.

(NINDS Wallenberg information page)

Progressive Supranuclear Palsy (PSP) is a disease of the brain which usually occurs in patients in their 60s, but can start as young as 40s. Survival rate is usually 6-10 years after first symptoms. In PSP, gradual loss of brain cells causes slowing of movement and reduced control of walking, balance, swallowing, speaking, and eye movement, especially downward direction. Other symptoms that occur in some are emotional and personality changes, such as increased irritability, angry outbursts, emotional lability, sleep disturbances, forgetfulness, mental slowing, apathy and difficulty with abstract reasoning. It is often mistaken for Parkinson's disease because of the slowness, and Alzheimer's because of the changes in mood and personality. The cause of PSP is unknown, but it is at least partly genetic. A brain protein caused tau accumulates in abnormal clumps in certain brain cells, causing the cells to die. There is currently no cure for PSP, although levodopa may give temporary benefit.
(The Society for PSP website)

Huntington's Disease is a hereditary disease which is caused by a faulty gene on chromosome 4. It is not yet fully understood how the faulty gene damages the nerve cells in the areas of the brain, including the basal ganglia and the cerebral cortex. Since so much of the brain's activity passes through these areas, the death of these cells affects virtually everything about a person, including movement, moods and thinking processes. Symptoms usually begin between the ages of 30-50 years, and an individual may have the disease for 15-20 years.

Neurosurgical

Intracranial Aneurysms are dilated blood vessels within the skull. Usually, the cause is unknown, but people with genetic causes of weak blood vessels are more likely to develop aneurysms. Rupture of intracranial aneurysms causes *subarachnoid haemorrhage* and has a poor prognosis. About 30% of people die within 24 hours, and a further 25-30% die within four weeks. Treatment for aneurysms involves either clipping the abnormal blood vessel, or coiling (*coil embolisation means the process by which a vessel is occluded with a material mass*). The coil technique involves approaching the aneurysm from inside the diseased blood vessel, avoiding the need to open the skull. A thin tube containing the coil on a guidewire is inserted into a large artery, usually in the groin, and passed up to the skull under radiological guidance. The coil is placed inside the aneurysm and detached from the guidewire. Multiple coils may be placed into the aneurysm until it is densely packed.
(NICE guidelines)

Craniotomy is the surgical removal of a section of bone (bone flap) from the skull for the purposes of operating on the brain. The bone flap is usually replaced at the end of the procedure. It is not replaced, the procedure is known as a **craniectomy**. A craniotomy is used for many different procedures within the head, e.g. trauma, tumour, infection, aneurysm.
(YourSurgery.com)

External Ventricular Drainage (EVD)*:* the brain and spinal cord are surrounded by cerebral spinal fluid (CSF) which helps protect them from damage. The area of the brain that contains this fluid are the ventricles. Sometimes, the CSF needs to be drained away from the ventricles, e.g. if there is a temporary blockage in the flow of CSF this will cause a build-up of CSF and a drain may be needed to reduce the pressure inside the brain. The EVD system uses a catheter placed in the ventricle of the brain and connected to a drainage system.
(Institute of Child Health)

Ventriculoperitoneal Shunt: This is a device which drains the extra fluid in the brain into the peritoneal cavity where the fluid can be absorbed.

Stereotactic surgeries are commonly used to treat Parkinson's Disease. The most important are ***deep brain stimulation (DBS), pallidotomy*** and ***thalamotomy***. Stereotactic just refers to the special frame that is attached to the head during surgery. DBS involves the permanent placement of electrodes into the thalamus, the pallidum, or the subthalmic nucleus. These are the parts of the brain that are involved in movement in PD. The electrode is connected to a small battery-powered stimulator which is implanted under the skin just below the collarbone, and there is a wire which runs under the skin to the electrode. The stimulator provides electrical impulses that affect the nerve cells and improve some of the symptoms. Thalamotomy and pallidotomy are performed when rigidity, hypokinesia and tremor are present, but DBS is not appropriate. For thalamotomy, a thin electrode is placed into the thalamus, and a high frequency electrical current is applied to the electrode destroying a small part of the tissue around it. This produces an immediate benefit in reduction of tremor (thalamotomy), rigidity and hypokinesia (pallidotomy). During thalamotomy, there is a small risk of permanent damage to the voice, and for both procedures a higher risk of stroke than with DBS.
(University of Virginia Health Systems website)

Caseload

The caseload is solely for inpatients.
The split between dysphagia and communication for inpatients in Neurosciences/Trauma is hugely variable but generally about 90% of patients are referred for dysphagia. Some of these patients will present with tracheostomies and some will also be ventilated. A good proportion of our patients may also have communication needs identified, e.g. dysarthria and dysphasia. On your placement you have the opportunity to see range of swallowing and communication impairments.

Opportunities for students in Neurosciences

1. You will have the opportunity to see acute inpatients.
2. You will take case histories and build up patient profiles.
3. You will have the opportunity to observe and participate in dysphagia assessments, treatment and reviews at the patient bedside.
4. You are likely to observe or carry out initial assessments for communication impaired clients and formulate profiles and plans.
5. You may have the opportunity to carry out some formal assessments
6. You will have the opportunity to observe and work jointly with the MDT to facilitate tracheostomy weaning.
7. You will be able to liaise with other members of the MDT including Doctors, Nurses, Dieticians, Physiotherapists, and Occupational Therapists.
8. You will gain experience at documenting patient records electronically.

Recommended Reading

You may find it useful to reacquaint yourself with notes from your neuroanatomy and physiology lectures.

It will be immensely helpful for you to review the overall organisation of the CNS and its divisions, the blood supply to the brain, the cranial nerves and the muscles they innervate, and the physiology of neurotransmission.

The following books offer a good source of information so you may wish to organise access to these for the duration of your placement with us.

'Neurology for the Speech - Language Pathologist', Russell J. Love & Wanda G. Webb, Butterworth – Heinemann. *This is somewhat of a 'bible' for this particular placement!*

'Evaluation & Treatment of Swallowing Disorders', Jerilyn Logemann, Pro-Ed.

Communication and Swallowing Management of Tracheostomized and Ventilator Dependent Adults (Dysphagia Series), Karen J Dikeman, Marta S. Kazandjian …

Tracheostomy: A Multi-Professional Handbook by Claudia Russell, Basil Matta

ENT DEPARTMENT, LG1 WEST WING, JOHN RADCLIFFE HOSPITAL

Welcome! We hope you enjoy your placement with us, and would like to make your time with us as fruitful as possible, aiming to share with you a wide variety of the aspects of managing a voice caseload. Whilst time can be limited, and caseloads pressurised, we value your active input into your placement. It makes us, as therapists, stand back and re-evaluate what we are doing.

The department is made up of 3 therapists who work the following sessions:

Laura Russell (Clinical Lead SLT) works Tuesday, Wednesday, Thursday and Friday

laura.russell@ouh.nhs.uk

Olivia Wheatley (SLT) works Monday, Tuesday, Wednesday

Olivia.wheatley@ouh.nhs.uk

Tor Spence (SLT) works Monday, Tuesday and Friday

Victoria.spence@ouh.nhs.uk

Our office is based in the
ENT department, Level LG1 West Wing, John Radcliffe Hospital, Oxford, OX3 9DU

Telephone: **01865 231204**.

http://www.ouh.nhs.uk/

This placement is suitable for students with mobility issues. A car is not essential. Up to one mile walking/cycling distances between Oxford hospital sites may be necessary without a car but hospital minibus transport is available.
If you are driving you can park in Car Park 3, which is directly under the West Wing building which you will see in front of you when you enter the hospital site; this is next to the Children's Hospital - it is clearly sign posted.
Come in the main entrance of the West Wing and go up the escalators to the first floor and follow signs on your left to ENT and audiology.
Reception will tell you where the speech and language therapy department is.
Allow at least 30 minutes for the bus from the station to the JR if you are coming by train (the direct bus from the Oxford train station to the JR is number 14; there is also a direct bus from Thornhill Park & Ride, number 800).

1. What kind of patients will I see?

Voice outpatients are seen for assessment and therapy, sometimes for second opinions of difficult cases, but also for routine voice therapy. You may have opportunity to observe ENT clinics, voice clinics, scoping clinics, Botox and medialisation clinics. Since September 2020 a large proportion of outpatients appointments have been carried out virtually. At present the department offers a mixed service and many patients are treated via video consultations.

2. How does the ENT Department work?

Voice patients are generally referred by their GP to the ENT medical team for laryngeal assessment and then to speech and language therapy. It is important that the larynx is

examined prior to us treating them with voice therapy in order to be sure of the pathology that we are managing.

There are specialist clinics run in the ENT Department which we are involved in, including: a twice monthly voice clinic, a monthly SLT led scoping clinic, a monthly Botox clinic for treatment of spasmodic dysphonia and a monthly medialisation clinic for vocal fold palsy. We will discuss dates/days of these during your placement with you, and if you are able to attend (which may mean swapping days) then you are welcome to attend as they will give you an opportunity to see specialist areas of ENT work.

3. Voice Therapy Cases

Some areas that may be helpful to spend some time focusing on include:

- Laryngeal pathology: laryngeal examinations are carried out in the Voice Clinic and, if it is possible, you will find it helpful to spend one session during your placement in the Voice Clinic observing laryngeal examinations. Try to relate what you know of the pathology to the sound of the voice that you are hearing.
- Assessments: This is a good opportunity to develop your case history taking and your voice assessment skills.
- Therapy techniques: Observe, read up, try out, be creative (there are a wide variety of techniques and sources available) but it is important to be sure that you have understood the rationale behind a technique that you are working with.
- Counselling: This is an integral part often of voice therapy. Be aware of your own limitations, use reflective practice and share your concerns and thoughts with your therapist.

Recommended Reading

Please read up on basic voice anatomy and physiology before the placement.

Some references which may be useful:

- The voice clinic handbook. Harris. T. 1998 Whurr publishers
- The voice and its disorders. Greene.M.and Mathieson.L. 2001 Whurr Publishers
- Psychology of voice disorders. Rosen.D and Sataloff R.1997 Singular
- Psychogenic voice disorders and cognitive behavioural therapy. Butcher, Elias and Raven. 1993 Whurr Publishers.
- Voice Work – Art and Science in changing voices. Christina Shewell. 2009 Wiley-Blackwell
- Voicefoundation.org
- Britishvoiceassociation.org.uk

UPPER AIRWAY/RESPIRATORY OUTPATIENT SERVICE

This service is led by:

Tor Spence (Clinical Lead SLT): Monday, Tuesday, Friday.
ENT Outpatients, Level LG1, West Wing, John Radcliffe Hospital
Victoria.spence@ouh.nhs.uk
01865231204

This placement will be with an upper airway/respiratory outpatient caseload. This includes patients with chronic cough, laryngeal hypersensitivity, Inducible Laryngeal Obstruction (sometimes Exercise Induced) and some dysphonia. Patients are referred to this service by GP, ENT, severe asthma service, Oxford respiratory centre and out of area respiratory clinicians.

We offer peer placements within this setting. Placements will include a mixture of face to face and remote working directly with patients, opportunity for learning about cough and upper airways management, nasendoscopy clinics and will involve running a virtual cough therapy group. All placements with this team will include working with the Severe Asthma MDT and the respiratory physiotherapy team.

Please contact Tor prior to the placement starting to discuss logistics.

KEY READING – Speech Pathology Management of Chronic Refractory Cough and Related Disorders. By Anne Vertigan and Peter Gibson. 2016. Compton Publishing.

Recommended but not mandatory reading:

Cough Management:

- Morrice et al. British Thoracic Society Cough Guideline Group. Recommendations for the management of cough in adults. Thorax. 2006; 61:11-24
- **Morrice et al. ERS guidelines on the diagnosis and treatment of chronic cough in adults and children. Euro Resp Journal. 2020 55**
- Gibson & Vertigan. Speech Pathology for chronic cough: A new approach. Pulm Pharma & Therpeu (2009)22: 159-162
- Morrice & Kardos. Comprehensive evidence-based review on European antitussives. BMJ. 2016
- Ryan N et al. Arnold's nerve cough reflex: evidence for chronic cough as a sensory vagal neuropathy. J Thorac Dis. 2014.
- Ryan N at al. Gabapentin for refractory chronic cough: a randomised, double blind, placebo-controlled trial. Lancet 2012.

Inducible Laryngeal Obstruction

- Low K et al. Abnormal Vocal cord function in difficult to treat asthma. Respir Crit Care Med 2011; 184: 50-56
- **Baxter, M et al. Multidisciplinary team clinic for vocal cord dysfunction directs therapy and significantly reduces healthcare utlization. Mar 2019: Respirology.**
- Newman KB, Mason UG, Schmaling KB. Clinical features of vocal cord dysfunction. Am J Respir Crit Care Med. 1995: 152; 1382-6.
- Carding, P. Paradoxical vocal cord movement: a rare condition that is likely misdiagnosed and mistreated. Clin Otolaryngology, 2000, 25, 241-243
- Christopher, KL, Wood RP, Eckert C et al. Vocal cord dysfunction presenting as asthma. N Engl J Med. 1983, 308, 1566-70
- Ibrahim, W et al (2007) Paradoxical Vocal cord motion disorder: past, present and future. Postgraduate Medical Journal, 83, 164-172

Exercise Induced Laryngeal Obstruction:

- Johansson H et al. Prevalence of exercise induced bronchoconstriction and EILO in a general adolescent population. Thorax 2015; 70:57.
- Nielsen EW et al. High Prevalence of EILO in athletes. Medicine Sci Sports Exerc 2013; 45: 2030-2035
- Heimdal J-H et al. Continuous Laryngoscopy Exercise test: A method for visualising laryngeal dysfunction during exercise. Laryngoscope 2006; 116:52-57.
- Maat RC et al. Audio-visual assessment of EILO: reliability and validity of observations. Eur Arch Oto-rhino-l 2009;266: 1929-1936
- Maat et al. EILO: natural history and effect of surgical treatment. Eur Arch Oto-rhino-l 2011 268(10); 1485-1492

THE BLENHEIM HEAD AND NECK UNIT, CHURCHILL HOSPITAL

The department is made up of five therapists working the following sessions:

Sam Holmes (SLT) works Monday -Thursday
Nikki Nash (SLT) works Mondays and Tuesdays and Friday from sept
Penny White (SLT) works Tuesdays Wednesday and Thursday
Charlotte Robinson (SLT Monday and Friday cover for Churchill at present**)**
Virginia Murray (SLT) works Monday , Tuesday and Thursday from sept

nikki.nash@ouh.nhs.uk
penny.white@ouh.nhs.uk
charlotte.robinson@ouh.nhs.uk
Samantha.holmes@ouh.nhs.uk
Virginia.murray@ouh.nhs.uk

Our office is based at:
Blenheim Head and Neck Unit
Churchill Hospital
Old Road, Headington
Oxford OX3 7LJ
Telephone no: **01865 231205**.

1. What kind of patients will I see?

We treat patients who have had head and neck cancer, either as an inpatient following surgery where their communication and swallowing problems are managed, or in multi-disciplinary clinics on an outpatient basis. We see patients during oncology treatment (radiotherapy and chemotherapy). There will probably be some laryngectomies that you will see as well and be able to observe a valve change. Seeing post-surgical patients, laryngectomy valve changes and patients undergoing radiotherapy can be daunting and, if you find anything you see distressing, please let your placement educator know.

2. How does the Blenheim Head and Neck Unit work?

The Head & Neck multi-disciplinary team includes Head & Neck Specialist Clinical Nurse team, Dietetics, Physiotherapists, and Ward Nurses, ENT, Maxillo-Facial and Plastic Surgeons, and Oncologists. You may find it interesting to spend some time with each of these if possible during your placement.

3. Head & Neck Cancer Patients

This is an opportunity to gain some insight into a specialised area which has its own challenges and can be daunting. You will not be expected to do any independent dysphagia work. You will find it helpful to relate the patients swallow and speech and relate it to anatomy and structural changes. Oxford is a central part of the Head & Neck Cancer Thames Valley Network. The surgery, chemotherapy and radiotherapy for patients over a large area takes place here.
We hope that you enjoy your placement with us, and welcome feedback both during and at the end of your placement to ensure that you find your time with us rewarding.

Recommended Reading

Revise head and neck cranial nerves, anatomy and physiology to help to get a good understanding of the site of a tumour, relating this to the resulting effects of the tumour on speech and swallow function, and understanding the management plan of treatment, both in surgery and in oncology.

- ‘Working with’ series
- Articles around head and neck, dysphagia and laryngectomy. Consider quality of life as well as outcomes from treatment on dysphagia
- Revise your head and neck lecture notes and look at the references from there. The Macmillan website has some good information on it.

CHURCHILL HOSPITAL, OXFORD

The Churchill Hospital is one of three acute hospitals in Oxford. The Adult Speech & Language Therapy Service covers the adult beds on site.

The Churchill Hospital currently provides an inpatient, ward-based service. The caseload is predominantly Dysphagia, which includes Tracheostomy management.
The acute services based at the Churchill Hospital include:

- Adult Intensive Care (AICU)
- Haematology
- Severe Chest conditions
- Renal impairment
- Infectious diseases
- Upper and lower Gastrology
- Oncology
- Urology
- Private patients

Liaising with the multidisciplinary team is an important part of our role. We have strong links with our colleagues in the Dietetics department, as well as communicating regularly with PTs, OTs, nurses, members of the medical team and other agencies, as cases require. When patients are transferred we liaise with other S&LTs in Oxfordshire, and out of county, to ensure a smooth transition for the patient and continuity of care.

What you will achieve from the placement

1. Opportunities to participate in dysphagia assessment.
2. Bedside assessment and rationale of what to use, and when.
3. Wide variety of impairments which impact on swallowing/communication.
4. Experience of considering/dealing with wider management issues of those with severe impairments/acutely unwell.
5. Opportunities to liaise with and observe other members of the MDT and carers.

The Churchill Hospital SLT team currently consists of the following therapists:

Charlotte Robinson (SLT) works Monday and Friday at present. Other cover is provided by the Blenheim Head & Neck team therapists.
Charlotte.robinson@ouh.nhs.uk

HORTON HOSPITAL, BANBURY

The Horton Hospital Speech & Language Therapist is:

Sharon Bunce Monday, Tuesday, Wednesday
Sharon.bunce@ouh.nhs.uk Thursday & Friday 8.30am – 4.30pm

Before you start

Please telephone or email the Speech Therapist to arrange a start time. Telephone number- 01295 229585 Monday – Friday. There is a confidential answerphone, feel free to leave a message.

General Information

The Horton Hospital is an acute general hospital providing a range of services. The following wards are likely to be visited during your placement.

Laburnum	Acute Medical Ward, including Acute and rehab stroke
Juniper	Acute General Medical Ward
EAU (Emergency Assessment Unit)	Covering all acute short term medical needs
F Ward	Trauma / Orthopaedics
CCU	Critical Care Unit – for acutely unwell patients

In addition to S&LT the multi-disciplinary team may include the following professionals:

- Doctor
- Nurse
- Therapy Assistant
- Physiotherapist
- Occupational therapist
- Dietician
- Social worker
- Pharmacist
- Clinical Nurse Specialists e.g. Palliative, Respiratory etc

Disorders and Caseload

The Speech & Language Therapist works with a wide range of medical, surgical and neurological disorders, including dementia, CVA, Parkinson's Disease etc.

Your placement is likely to provide you with a variety of swallowing and communication disorders.

Opportunities for Speech & Language Therapy Students

1. You will have the opportunity to observe / work with in-patients within the acute and sub-acute setting and where appropriate, have the opportunity to observe / participate in :

(a) Dysphagia assessments and reviews.

(b) Taking case histories.

(c) Initial assessments for communication impaired clients.

(d) Formal and informal assessments.

(e) Planning and carrying out therapy.

(f) Liaising with other members of the MDT team. Short observation visits can usually be arranged with PT, OTs, etc. if useful.

(g) Experiencing a range of report-writing, note taking, record-keeping etc.

(h) Some admin duties, e.g. Referral / discharge procedures, be aware of local Trust policies etc.

Recommended Reading

1. Access to a general book on dysphagia will be valuable, e.g. “Working with Swallowing Disorders” by Judith Langley & / or Swallowing Disorders by Logemann.
2. Depending on the clients seen, you are likely to need to read books/articles on the following subjects:
   - Aphasia assessment, therapy and management
   - Dysarthria assessment, therapy and management
   - Dyspraxia assessment, therapy and management

JOHN RADCLIFFE HOSPITAL, OXFORD

The JR SLT team currently consists of the following therapists:

Inpatient Team

Alison Faulkner — SLT Service Manager
Alison.Faulkner@ouh.nhs.uk

Beatriz Santos — Acute Clinical Lead (currently on career break)
Beatriz.santos@ouh.nhs.uk

Charlotte Robinson
Charlotte.robinson@ouh.nhs.uk

Holly Davies — Currently on maternity leave
Holly.Davies@ouh.nhs.uk

Stroke Unit

Abigail Waldock — Monday, Tuesday, Wednesday
Abigail.waldock@ouh.nhs.uk

Olivia Wheatley — Thursday and Friday
Olivia.wheatley@ouh.nhs.uk

Andrea O'Donoghue — Monday - Friday
Andrea.O'Donoghue@ouh.nhs.uk

Advanced Support Workers:

Magdalena Fras — Monday - Friday
Stroke Unit
Magdalena.Fras@ouh.nhs.uk

Ursula Warnecke provides admin support throughout the week (flexible).

Telephone contact: 01865 743133

The John Radcliffe Hospital (JR) is one of three acute hospitals in Oxford. The Adult Speech & Language Therapy Service covers the adult beds on site, and our paediatric colleagues see the paediatric inpatients.

This placement is suitable for students with mobility issues. A car is not essential. Some walking between wards is required, lifts are available.

The JR currently provides an inpatient, ward-based service only. The caseload is predominantly dysphagia, which includes tracheostomy management. However, communication input is given where able.

The acute services based at the JR include

- Acute Stroke Unit (ASU)
- Adult Intensive Care (AICU)
- Cardiology
- Cardio-thoracic surgery and intensive care
- General medicine
- Vascular surgery
- Haematology
- Geratology
- Respiratory
- Trauma, including spinal injuries

Patients present with a wide variety of aetiologies such as:

- CVA
- Traumatic Brain Injury
- Multiple Sclerosis
- Parkinson's Disease
- MND
- Dementia
- Poly-trauma
- Cardiac or cardio-thoracic issues

Liaising with the multidisciplinary team is an important part of our role at the JR. The Acute Stroke Unit has daily MDT meetings whereas, on the other wards/units, liaison is as necessary. We have strong links with our colleagues in the Dietetics department, as well as communicating regularly with Physiotherapists, Occupation Therapists, nurses, members of the medical team and other agencies, as cases require. When patients are transferred we liaise with other SLTs in Oxfordshire, and out of county, to ensure a smooth transition for the patient and continuity of care.

What you will achieve from the placement

1. Opportunities to participate in dysphagia assessment.
2. Bedside assessment and rationale of what to use, and when.
3. Experience with a wide variety of impairments, including the impact of dementia on swallowing/communication.
4. Experience of considering/dealing with wider management issues of those with severe impairments/acutely unwell.
5. Opportunities to liaise with and observe other members of the MDT and carers.
6. Opportunity to observe Videofluoroscopy clinics.

Oxford University Hospitals
NHS Foundation Trust

EARLY SUPPORTED DISCHARGE (ESD) FOR STROKE

SLT Contact: Lauren Kuepper
Lauren.Kuepper@ouh.nhs.uk
Mobile: 07919 692043
Office: 01865 572723

Our office is based at the Oxford Centre for Enablement
Windmill Rd
Headington
Oxford
OX3 7LD

We currently offer an Early Supported Discharge service 2 days per week. The service is able to provide patients with intensive therapy support at home based from the hospital for up to 6 weeks following discharge from the Acute Stroke Unit, and the TIA clinic.

This placement is suitable for students with mobility issues. Some walking between offices-car and car-homes will be required.

SLT input in ESD is largely for communication therapy – dysphasia, dyspraxia and/or dysarthria, although occasional dysphagia reviews are also carried out. There are also frequent opportunities for joint working with other members of the MDT and joint goal setting.

We have a weekly MDT meeting on Tuesday mornings, where all patients on the caseload are discussed.

The ESD team consists of:

Occupational Therapists
Physiotherapists
Speech and Language Therapists
Rehab Assistants

A car is not essential to attend this placement.

Please contact Lauren for further information before the start of your placement.

Oxford Centre for Enablement (OCE), NUFFIELD ORTHOPAEDIC CENTRE, OXFORD

The Oxford Centre for Enablement is a purpose-built centre which provides specialist neurological rehabilitation and disability services. It is situated at the Nuffield Orthopaedic Centre, Windmill road, Headington, Oxford, OX3 7HE.

This placement is suitable for students with mobility issues. A car is not essential. Up to one mile walking/cycling distances between Oxford hospital sites may be necessary without a car but hospital minibus transport may be available

The services included here are:

- Neurological Rehabilitation service (NRS - inpatient and outpatient)
- Neuro-Enablement Day Hospital (NEDH)
- Oxfordshire Wheelchair Service
- Rehabilitation Engineering
- Specialist Disability Service (SDS)
- Prosthetics service
- Orthotics service

http://www.ouh.nhs.uk/oce/services/default.aspx

There are 2 SLT departments within OCE

- The AAC Service, based within SDS – 01865 737445
- SLT team providing input to NRS (Neuro-Rehabilitation Service) & NEDH (Neuro-Enablement Day Hospital) – 01865 737335

NEDH / NRS SLT Team:

The current staffing includes:

Angela Kavanagh, Highly Specialist SLT	Monday – Friday
Edel Murphy, SLT	Monday – Friday
Cheryl Horsey, SLTA	Monday – Wednesday

Types of clients seen at OCE:

On placement with the NRS / NEDH SLT team you will observe and work with clients with communication disorders and/or swallowing problems related to acquired Neurological illness or injury. This may include:

- CVA
- Head injury
- SAH
- Encephalitis
- Progressive Neurological illnesses, e.g. MND, MS, PD or PD plus, HD

Frequency of input in NRS
Depending on the client's rehabilitation need and Speech and Language Therapy staffing levels, we aim to see NRS inpatients 3-5 times per week if their rehabilitation needs from Speech and Language Therapy are high and they can benefit. This is dependent on staffing levels and numbers of patients requiring SLT. We aim to offer a combination of one to one sessions with Speech and Language Therapists and assistants, joint sessions with other disciplines in the interdisciplinary team, and a supported conversation group where appropriate and possible.

Goal planning – The rehabilitation is planned and structured within a multidisciplinary goal planning framework for each inpatient seen in the neuro-rehabilitation service.

NEDH (Neuro-Enablement Day Hospital)

This is a service for people who live in their own homes and who have a complex neurological disability, e.g. Motor Neurone Disease, Multiple Sclerosis, Huntington's Disease and others.

Clients attend for block day services or one day per week

The service works with clients to increase their abilities in the following areas: physical, emotional, communication and cognition.

Speech & Language Therapy input comprises one-to-one sessions and communication groups.

The team comprises - medics, nurses, occupational therapy, physiotherapy, speech and language therapy, clinical neuropsychology, leisure services, social services, community care managers and pastoral care.

Referrals come from acute services, GPs, allied health professionals or other rehab services.

Recommended reading:

1. A cognitive neuropsychological approach to assessment and intervention in aphasia; a clinician's guide (2005). Whitworth, A., Webster, J. & Howard, D. Psychology Press.
2. Management of adult neurogenic dysphagia (2003), Huckabee, ML. & Pelletier, CA. Thomson Delmar Learning
3. Cognitive-communicative abilities following brain injury; a functional approach (1995). Hartley, LL. Thomson Delmar Learning

AAC SERVICE

Clinic Location: Specialist Disability Service, Oxford Centre for Enablement, Nuffield Orthopaedic Centre

This placement may not be suitable for students with mobility issues. A car is not essential.

Staffing

Tracy Phillips (SLT): tracy.phillips@ouh.nhs.uk Monday – Friday
01865737445
0778 9944225

Alice Clark (SLTA) Mon, Tues, Thurs, Fri
01865 737445

Input to the AAC Service can also provided by members of the SDS team if needed, including:
Laurence Wright – Occupational Therapist
Rob Lievesley – Clinical Scientist
Jacqueline English – Therapy Technician
Said Akbar – Electronics Engineer

Where and how the service is provided:

The AAC service is part of the Specialist Disability Service, which is a tertiary level service for the management of people with complex disabilities. Clients can attend as outpatients, but the majority are seen at home, or in any other appropriate setting. Services available include AAC, Computer access, environmental control, wheelchair adaptations, specialised seating, 24 hour posture management, baby care for parents with a disability, mobile arm support.
https://www.ouh.nhs.uk/oce/services/specialist-disability-service/

The AAC Service is a local AAC service. The majority of referrals are for Oxfordshire clients, but referrals can be accepted from other areas if funding is agreed. Input includes assessment, trial of equipment, provision of equipment for (Oxfordshire) clients who do not meet the criteria for Specialised AAC Service (subject to funding availability) and ongoing review.

The AAC service provides assessment and advice about communication aids. Referrals are accepted for high tech communication aids, however, low tech strategies are also always considered. Introducing any AAC system usually involves a significant amount of support. Referrals are also made to Specialised AAC services and support provided for these referrals.

Caseload

The majority of clients have Progressive neurological conditions, e.g. MND, PD, MS, HD

Aphasia	Stroke
Dysarthria	Cerebral palsy
Apraxia of speech	Brain injury
Dysphonia	

What you can expect from your placement

- Understanding of a range of low and high-tech AAC systems
- Opportunities to work with members of the multi-disciplinary team
- Understanding of the skills required to use AAC
- Possible opportunities to assess patients and train them and carers to use AAC
- Understanding of holistic patient care
- Involvement with a wide range of client groups

Recommended reading

Please read the Focus On leaflets on the following link.
http://www.communicationmatters.org.uk/page/focus-on-leaflets