

## CONNECTICUT VALLEY HOSPITAL OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 2:</b>	Provision of Care, Treatment and Services
<b>PROCEDURE 2.43:</b>	<b>Speech and Language/Communication Services</b>
<b>REVISED:</b>	Reviewed 02/18
<b>Governing Body Approval:</b>	1/28/16 ( <i>New</i> ); 04/18

**PURPOSE:** This service is to ensure patients at Connecticut Valley Hospital (CVH) are able to communicate their needs functionally and to their maximum potential in their current environment.

**SCOPE:** All clinical staff.

**Criteria:**

To determine if a patient is appropriate for skilled speech and language (communication) referral, a patient must experience difficulty communicating their needs effectively. Upon completion of the assessment, skilled services are identified by the Speech Language Pathologist's (SLP's) findings and clinical judgment. Skilled services are identified when patients possess higher level cognitive skills in order to develop goal directed communication behaviors. These cognitive-communication behaviors include, but are not limited to: self-monitoring, initiation, attention, memory, motivation, and the ability to follow cues or directions. These communication behaviors may consist of poor speech intelligibility, fluency, voice disorders, and cognitive impairments.

**PROCEDURE:**

In the event a communication impairment appears to be present, the following actions will be taken:

1. The communication impairment will be immediately reported to the RN followed by a progress note. RN will notify the Physician/APRN and request an order for a Speech-Language/Communication Assessment from Speech Pathology. The Referral for Speech-Language Pathology Services Form [CVH-604](#) (located at [T:\Forms\HIM\Speech Language Pathology Forms\Speech-Lang Referral.604.doc](#)) will be completed by the RN and faxed to Speech Pathology at x7115.
2. Upon completion of the Speech and Language Assessment, the Speech Language Pathologist (SLP) will verbally report the recommendations to the charge nurse who will notify the Physician/APRN for orders. The SLP will file the assessment in the assessment section of the chart, and a note in the progress notes of the findings and recommendations.
3. The SLP will document on the Medical Rounds Communication Board that the assessment has been completed, and attach the assessment to the Physician/APRN board for review.

4. The SLP will document each treatment in the progress notes following written order from Physician/APRN.

**Discharge/Termination from Speech and Language Treatment:**

1. The last note of treatment will be identified as a Discharge Summary in the progress notes. The patient is discharged from speech and language treatment by the SLP when the patient has achieved one of the following criteria:
  - a. The patient has achieved their communication treatment goals.
  - b. The patient's communication skills have reached maximum potential in their current environment.
  - c. The patient has refused 3 consecutive treatment sessions.