T-LEVELS | Institute for Apprenticeships & Technical Education

# T Level Technical Qualification in Health

Occupational specialism assessment (OSA)

# Supporting the Therapy Teams

Assignment 1 - Case study - Distinction

Guide standard exemplification materials

v1.1: Specimen assessment materials
September 2021
603/7066/X

Internal reference: HLTH-GSEM-26

NCFE CACHE

**T Level Technical Qualification in Health**
**Occupational specialism assessment**

# Guide standard exemplification materials

## Supporting the Therapy Teams

Assignment 1

## Contents

# Introduction

The material within this document relates to the Supporting the Therapy Teams Occupational Specialism sample assessment. These exemplification materials are designed to give providers and students an indication of what would be expected for the lowest level of attainment required to achieve a pass or distinction grade.

The examiner commentary is provided to detail the judgements examiners will undertake when examining the student work. This is not intended to replace the information within the qualification specification and providers must refer to this for the content.

In assignment 1, the student must interrogate and select relevant information to respond to the tasks in ways typical to the workplace. By adopting a problem-based inquiry approach, the student is placed at the centre of decision-making regarding an individual's care in a scenario designed to be as realistic as possible.

After each live assessment series, authentic student evidence will be published with examiner commentary across the range of achievement.

# Scenario

You have been assigned to assist the allied health professional (AHP) therapy team on a stroke rehabilitation ward in an acute hospital.

You will be working with a range of therapists and specialists and the documents in this case study will help you to understand the range of work the team is involved in delivering.

Documents to review:

- Gugging Swallowing Screen (GUSS) - assessment (item A)
- Gugging Swallowing Screen (GUSS) - evaluation (item B)
- National Institute for Health and Care Excellence (NICE) pathways stroke rehabilitation flowchart (item C)
- healthcare support worker blog (item D)
- baseline assessment tool for NICE guideline on stroke rehabilitation (CG162) (extract) (item E)
- stroke handbook (Link 1)

# Task 1: Assessment of the patient/situation

## Scenario

Claire Smith has been admitted to the ward after suffering a stroke whilst at home this evening.

You are assisting a staff nurse as they use the Gugging Swallowing Screen (GUSS) (items A and B) to inform decisions about the care that Claire will receive. Look at the results of the assessment in the attached document.

## Task

Make an assessment of Claire's needs, incorporating principles of patient-centred care. You must include:

- a summary and rationale of Claire's individual needs, with reference to her GUSS score
- specific guidance to the catering staff about Claire's nutritional requirements
- an evaluation of Claire's immediate needs for the first night on the ward in line with stages 2 and 3 of the NICE stroke rehabilitation pathway (item C)

# Student evidence

Claire's GUSS score is 17/20, which means she has 'slight dysphagia with a low risk of aspiration'. According to the GUSS evaluation, this means she needs a dysphagia diet and should drink liquids very slowly. The preliminary investigation and direct swallowing test results shows us Claire did not have problems swallowing semisolid food or liquids and did not experience coughing, drooling or voice change during the assessment. Her score is moderate in the severity code of 15–19 and so ward staff should work to improve swallowing and return to a normal diet as soon as possible.

Claire will need help from the allied health professional/therapy team to manage her food and drink intake, especially a speech and language therapist (SaLT). The SaLT will be able to work with the ward nurses to make sure Claire's needs are fully explored and understood and that she is provided with appropriate food, drinks and support. They may also consider further evaluations of swallowing, such as an endoscopy. This will help the rehabilitation plan to progress more rapidly because it means staff have a continual understanding of her needs.

The nurse and therapy team should ask Claire about her favourite foods and drinks and find out about her usual eating patterns. This might help her feel more relaxed on the ward and support a less stressful recovery. This information should be included in her care plan as part of the person-centred care approach. It will help Claire to establish routine and she will be more likely to engage in rehabilitation therapy because she feels she has some control over her care and treatment.

The catering staff should provide Claire with pureed and soft food she can swallow easily without a lot of chewing. As she has been admitted to hospital, she will not be able to have her usual meals and so the caterers should make sure food is nutritious and tasty. This will help Claire adjust to a new type of food until her swallowing fully returns. The ward staff should request mashable food that is to Claire's likes and monitor her intake to ensure she receives enough nutrition. The SaLT, in consultation with a dietician, may consider oral supplements whilst in hospital. The catering team should provide appropriate cutlery to go with pureed food, such as spoons instead of a knife and fork. They may also wish to provide modified cups or straws to help Claire drink more slowly.

The NICE pathways stroke rehabilitation flowchart lists 'information, support and training' and 'screening and assessment' as the next steps in stroke rehabilitation. These stages are listed straight after a person has had a stroke and the ward team should carry them out straightaway, alongside baseline clinical measurements and a medical history to identify causes of the stroke. They will need to make sure Claire has been provided with information about what a stroke is and about what will happen during her rehabilitation. Staff will also need to

provide emotional support in addition to medical support and offer Claire information on how she can better take care of herself during rehabilitation therapy. Her needs on the first night are likely to be to understand her condition and prognosis and to understand the rehabilitation plan. Staff should work with her to support goal-setting and an activities of daily living plan, both of which should be set early and reflect specific lifestyle measures, such as professional life, personal life and hobbies. For example, the team need to consider if her ability to do her job is likely to be impinged by stroke rehabilitation. This work should consider Claire's psychological disposition, her personal needs and should initially follow NICE guideline NG128 relating to stroke care.

# Task 2: Goals/patient outcomes/planned outcomes

## Scenario

Some stroke individuals may be on wards for significant periods of time. Prior to hospital admission, patients often have busy social lives, hobbies and careers. This means ward managers need to consider the impact of social isolation on patients' health and wellbeing. The ward manager has asked you to identify some appropriate and useful activities that can be used to help improve the social integration and resilience of longer stay patients. While activity volunteers are available in the hospital, they tend to focus on the elderly care wards.

Sam Wilson's blog entry (item D) explains how he supports inpatients on a ward to engage in activities, which should be considered alongside the Stroke handbook (Link 1) about life on the stroke ward.

## Task

Evaluate the possible options available to plan and deliver an activity programme utilising the skills and roles in the therapy team to support the needs of longer stay patients.

You can find the types of therapists likely to be available on the stroke ward in the stroke handbook (Link 1).

# Student evidence

Social isolation can occur amongst patients whose hospital stay is extended, and particularly when they do not have a discharge date to look forward to. The impact can be dangerous for patients trying to recover because it can slow rehabilitation, foster loneliness and reduce overall wellbeing. This might result in depression, anxiety and feeling detached from hobbies and activities usually important to them. Medical conditions can also be affected by social isolation, such as pressure sores because the patient does not move often enough, or malnutrition and unplanned weight change.

The therapy team, including occupational therapists, physiotherapists, speech and language therapists, dieticians and therapy assistants, should be involved in an activity plan. Wider holistic approaches to therapy roles could help patients in these circumstances, such as art and music therapists. There is a lot of evidence that both of these approaches can significantly improve emotional wellbeing and outcomes and improve resilience for those with long-term hospital admission.

Therapy assistants could be particularly helpful as they can help with an activity plan that has input from the whole team and is clinically useful as well as stimulating for the patient. Therapists can help patients with a broader holistic role that combines clinical care with activities that help patients relax.

Sam's ideas in his blog could be useful for long-stay patients. Giving them some space away from the clinical area to be creative would be a good start because it could help to lift their mood and make them feel energised. We could form a therapeutic group, which Sam notes can speed up recovery. The programme should be informal, relaxed and help patients to have a laugh and some relief from the ward routine. While therapists can plan and facilitate this, patients should be at the centre of the process and their physical and mental limitations should be considered.

Therapists should ask each patient about their likes and dislikes, and what they would normally do for fun and leisure at home. The activities coordinator could also discuss their work and social lives and find out which elements they were missing to help incorporate activities to keep their minds active. Therapists should also consider limitations of time, resources, and the environment and ensure that the available staff have the experience and competence to support effective activities.

We can discuss the role of volunteers with their manager and find out why they do not provide a service to

patients on the stroke ward. If we can secure volunteer time, then patients can have more recreation time. If we can provide evidence for improved patient outcomes then the volunteer team might be able to help, especially if we use examples such as the Royal Voluntary Service ‘On Ward’ example. Therapists can support volunteers to understand different activities and help them to facilitate safely. Whoever is delivering activities needs to ensure an up to date risk assessment is completed for each person and each activity. This should reflect staff skillset and the equipment or environmental adjustments needed to deliver activities.

# Task 3: Care/treatment/support plan

## Scenario

The ward manager has asked you to support a physiotherapist as they treat Sylvie, a 60 year old patient. Sylvie is coming to the end of her inpatient rehabilitation programme after suffering a stroke and will need a long-term plan for health and social care support in the community.

Sylvie is able to walk independently with one stick for short distances but still requires assistance of one person when climbing stairs. She is occasionally incontinent when not able to get to the bathroom quickly and is still having some word finding difficulties along with significant fatigue.

The physiotherapist has been using the NICE baseline assessment tool for stroke rehabilitation (CG162) (item E) as they work towards Sylvie's discharge.

## Task

Read NICE CG162 recommendation 1.11 (item E) in your case study pack.

The physiotherapist asks if you would like to observe the discharge care meeting with Sylvie. In preparation for this, you are required to:

- identify what needs to be established for a discharge care plan
- provisionally assess Sylvie's needs, based on the information you have
- explain how individual practitioners from the therapy team could help meet Sylvie's individual needs

# Student evidence

While planning for Sylvie's discharge is a positive point in her rehabilitation, on-going care planning must recognise that she still has a number of clinical challenges. Discharge planning should focus on promoting independence alongside long-term needs. The physiotherapist should, as a minimum:

- establish how Sylvie will access care in the community and ensure a smooth clinical handover takes place to each service
- provide information to Sylvie to help her understand potential complications and risks and to prevent future hospitalisation and ensure she understands which service to contact for help and when
- consider Sylvie's social and holistic needs in addition to physical therapy rehabilitation needs - this could include patient-defined outcomes, lifestyle priorities and goal-setting to make sure clinical priorities are mapped with Sylvie's personal goals
- ensure the care plan is long term and includes timely reviews as well as indicators of success - this should identify benchmarks and milestones and enable the multidisciplinary team to identify when progress has been made and when interventions may need to be increased
- ensure there is pharmacy input to manage Sylvie's medication and to work with her to make sure the prescription is effective and appropriate
- implement a strategy to measure clinical and rehabilitation outcomes, such as changes in baseline physiological measurements, changes in mental and physical ability, and a plan to respond to unexpected deterioration

The physiotherapist should work with Sylvie and the rest of the multidisciplinary team to make sure the plan is person-centred and reflects what is important to her, such as her goals and aims. Other things to consider are the types of equipment Sylvie will need at home and whether she will need on-going support from therapists. This should be as specific as possible and consider Sylvie's holistic care needs, such as her wish to resume hobbies

and social activities.

Sylvie still has some needs around mobility and cannot climb stairs by herself. If her home has stairs then this means she will need a stairlift, which should be in place for when she is discharged. The therapy team should ensure Sylvie has the physical and mental ability to use this device and that she is happy with it before it is installed. Staff also need to consider how to deal with her incontinence and fatigue. These issues could affect Sylvie's day to day life quite a lot and would stop her from being social and active. The physiotherapist should take this into account and consider extra support, including from carers such as family and friends, and from the wider therapy and multidisciplinary teams. For example, care should be taken to identify specific individual roles and how this will contribute to Sylvie's wellbeing and recovery.

Community therapists will be able to support Sylvie in her rehabilitation. A physiotherapist will be able to support long-term recovery and help with improving mobility and dexterity. An occupational therapist will be able to help Sylvie take up her favourite hobbies again by helping with independence. They will work as part of a wider team, including Sylvie's GP, to promote recovery and wellbeing. Each should work according to NICE guidance and deliver ongoing care and support that is individualised and considers Sylvie's views and wishes.

# Task 4: Evaluation/monitoring effectiveness/clinical effectiveness

### Scenario

Sylvie is keen to return to her full-time job as a community arts theatre manager and hopes to resume this shortly after she is discharged home. In this role, Sylvie coordinates the event calendar, theatre budget and team of staff.

The therapy team supports inpatients through their rehabilitation using the appropriate NICE pathway (item C). Look at this document in your case study pack.

### Task

Analyse the features of Sylvie's early supported discharge from hospital to her home in the community. As part of your answer:

- provide key recommendations for the therapy team to evaluate the effectiveness of this discharge
- evaluate the features of Sylvie's return to work considerations following her stroke and justify key recommendations for the therapy teams to have considered

## Student evidence

According to the NICE pathway, there are 4 stages after early supported discharge: 'systems to ensure safe transfer of care', 'transfer of care from hospital to community', 'return to work' and 'long-term support'. 'Systems to ensure safe transfer of care' are required before a patient could safely return to work and is not part of the specific process; it is an essential requirement for the discharge to be safe and successful; such a plan will include appropriate risk assessment, management and mitigation that includes Sylvie's physical and mental health needs. For example, occupational therapists can help Sylvie with a smooth return to work if they deliver care that is integrated with the rest of the wider team.

One of Sylvie's key goals is to return to work and the discharge plan should focus on what she will need to achieve this. Long-term support will be necessary once Sylvie has returned to work and should be holistic in nature, considering physical, psychological and rehabilitative needs. To evaluate the effectiveness of the discharge, the therapy team should consider the steps Sylvie needs to accomplish before she can return to work. These include reducing fatigue, improving continence and improving mobility and addressing any broader mental health needs such as cognitive function.

A discharge and return to work plan should include input from the multidisciplinary team, particularly when considering how the discharge can take place safely. For example, nurses, consultants and the district nursing team. The plan should be based on a transitional care model in line with NHS community pathways and therapist-led resources, such as therapy outcome measures (TOMs) to demonstrate how community care is different from hospital care and include support for Sylvie to access local resources herself.

The therapy team also need to consider how to plan long-term, individualised support, and what this might look like for Sylvie. For example, as she manages a team of staff, she will need support to improve cognition as the ward team noted she sometimes experiences confusion when trying to find the right words. There may also be barriers to good outcomes, such as unexpected setbacks in health and disruptions to local community service availability.

Considerations at work need to centre on Sylvie's physical health and safety and her ability to carry out her duties. This is part of her rehabilitation as she wants to return to work and the therapy team should ensure the care plan is centred on this. Environmental adjustments should be considered at work to support Sylvie with

access issues, such as whether a lift is available if the theatre is not located at ground level on a single floor. In addition, if Sylvie's incontinence is not addressed then consideration should be given to the availability of toilets in the theatre and what can be put in place to support rest periods.

Sylvie might experience setbacks during rehabilitation and her return to work and the discharge plan should identify how staff will support her with these and ensure she does not experience deterioration as a result. The plan should also evidence how Sylvie has been consulted in the content and what she would view as success or failure, and what she anticipates her key challenges to be.

# Examiner commentary

The student adeptly communicated the relationships between person-centred care and maintaining safety, including physical and mental wellbeing, in the scenario. Links were constructive and meaningfully contributed to the patient's outcomes. The student proficiently explained the principles of such areas of work and in areas relevant to supporting therapy teams and confidently adapted these to individuals receiving care or working with colleagues. They had awareness of codes of conduct, duties of care and the duty of candour in the scenario that required safeguarding acumen and an understanding of safeguarding risks that was individualised, empathetic and evidence based. They applied a very good understanding of resources and equipment required to work in safeguarding scenarios safely and appropriately.

The student understood their scope of practice and identified strengths, weaknesses and opportunities for learning in the context of their own experience and in application with specific scenarios. They understood the markers of clinical deterioration, including actions they could take to reduce risk and the documentation needed, with named examples of policies and care pathways.

The student accurately and effectively reviewed documentation to make recommendations that positively influenced patient care and outcomes, with a clear evidence base. Their recommended support was very well justified with relevant evidence and in line with named guidance. The student identified the fluid nature of recommendations and applied these as a tool to continuously review and monitor patient progression as part of a broader therapy team.

The student communicated relevant knowledge of the scope and limitations of their healthcare role within national and local structures by identifying team working practice and approaches to assist professionals with current best practice interventions to support individuals to maintain dignity. This was a personalised approach in line with demonstrable understanding of person-centred care. They understood the purposes of gathering information and maintaining records in line with legislation and maintaining individuals' rights within broader data management contexts, including named legislation.

The student communicated reliable information on physiological states because of their confident understanding of the correct use of equipment to monitor and calculate scores and differentiate and escalate results appropriately under supervision and guidance.

# Overall grade descriptors

The performance outcomes form the basis of the overall grading descriptors for pass and distinction grades.

These grading descriptors have been developed to reflect the appropriate level of demand for students of other level 3 qualifications, the threshold competence requirements of the role and have been validated with employers within the sector to describe achievement appropriate to the role.

# Occupational Specialism overall grade descriptors*:

| Grade | Demonstration of attainment |
|---|---|
| Pass | A pass grade student can:<br>• communicate the relationship between person-centred care and health and safety requirements in healthcare delivery by:<br>o demonstrating working in a person-centred way, taking relevant and sufficient precautions to protect the safety and physical and mental wellbeing of individuals<br>o recognising and responding to relevant healthcare principles when implementing duty of care and candour, including the demonstrating sufficient knowledge of safeguarding individuals and maintaining confidentiality<br>o following standards, codes of conduct and health and safety requirements/legislation to maintain a sufficiently safe working environment<br>o demonstrating use of an adequate range of techniques, equipment and resources safely to promote sufficient levels of cleanliness and decontamination required for satisfactory infection prevention and control<br>• communicate knowledge of national and local structures, definitions of clinical interventions, the scope and limitations of their healthcare role within it, by:<br>o adequately following current best practice and codes of conduct across relevant boundaries, relevant to assisting with scenario specific, clinical and therapeutic interventions.<br>o working adequately as part of a team to assist registered health professionals with delegated tasks and interventions, supporting individuals to meet their care and needs to a satisfactory standard, including maintaining individual's privacy and dignity and communicating effectively, contributing to handovers, seeking help, advice and information, and responding sufficiently to service users views to maintain effective provision of services<br>o gathering sufficient evidence, contributing to, following and recording information in care plans/records relevant to tasks and interventions, structuring these sufficiently to allow understanding in line with local and national legislation and policies, preserving individuals' rights<br>o maintaining a record of professional development with evidence of using feedback to develop knowledge, skills, values and behaviours consistent with sufficient ability to reflect on practice and thereby improve performance adequately<br>• communicate sufficiently reliable levels of knowledge of the physiological states that are commonly measured by healthcare support workers including why, when and what equipment/techniques are used by:<br>o working as part of a team to use relevant equipment effectively and safely and following correct monitoring processes |

| Grade | Demonstration of attainment |
|---|---|
| | ○ calculating scores, reporting and differentiation of normal and abnormal results to the relevant registered professional<br>○ applying knowledge of policy and good practice techniques when undertaking all physiological measurements, checking when uncertain and consistent with instructions and guidance |
| Distinction | A distinction grade student can:<br>• communicate adeptly the relationship between person-centred care and health and safety requirements in healthcare delivery by:<br>○ demonstrating flexible and constructive person-centred care, taking appropriate precautions reliably, making sound decisions to protect the safety and physical and mental wellbeing of individuals<br>○ alertness and responsiveness to relevant healthcare principles when implementing duty of care and candour, including the demonstration of exceptional sensitivity and accurate knowledge of safeguarding individuals and maintaining confidentiality<br>○ commitment to following all required standards, codes of conduct and health and safety requirements/legislation decisively to maintain a safe, healthy working environment<br>○ demonstrating proficient use of an extensive range of techniques to promote optimum levels of cleanliness and decontamination required for effective infection prevention and control<br>• communicate knowledge of national and local structures, definitions of clinical interventions, the scope and limitations of their healthcare role within it, by:<br>○ following current best practice and agreed ways of working highly relevant to assisting with scenario specific, care-related tasks consistently and reliably, whilst fully supporting individuals to meet their care and needs including maintaining the individual's privacy and dignity to a high standard<br>○ working adequately as part of a team to assist registered health professionals with delegated tasks and interventions, supporting individuals to meet their care and needs to a satisfactory standard, including maintaining individual's privacy and dignity and communicating effectively, contributing to handovers, seeking help, advice and information, and responding sufficiently to service users views to maintain effective provision of services<br>○ gathering extensive evidence consistently, interpreting, contributing to, following and recording information in care plans/records which is highly relevant to tasks and interventions, structured accurately and legibly and in line with local and national policies, while preserving and promoting individuals' rights<br>○ maintaining a record of professional development to develop knowledge, skills, values and behaviours consistent with ability to reflect on practice enthusiastically, using the feedback to initiate new learning and personal practice development to improve performance with developing proficiency<br>• Communicate exceptional levels of knowledge of the physiological states that are commonly measured by healthcare support workers including why, when and what equipment/techniques are used by:<br>○ working as part of a team to use relevant equipment accurately and safely and consistently following correct monitoring processes |

| Grade | Demonstration of attainment |
|---|---|
| | ○ calculating scores, reporting and differentiation of normal and abnormal results adeptly, consistently and reliably to the relevant registered professional<br>○ applying knowledge of policy and good practice techniques proficiently when undertaking all physiological measurements, checking when uncertain, solving problems, and following instructions and guidance with energy and enthusiasm |

* “threshold competence” refers to a level of competence that:

- signifies that a student is well placed to develop full occupational competence, with further support and development, once in employment
- is as close to full occupational competence as can be reasonably expected of a student studying the TQ in a classroom-based setting (for example in the classroom, workshops, simulated working and (where appropriate) supervised working environments)
- signifies that a student has achieved the level for a pass in relation to the relevant occupational specialism component

# Document information

The T Level Technical Qualification is a qualification approved and managed by the Institute for Apprenticeships and Technical Education.



Owner: Head of Assessment Design

## Change History Record

| Version | Description of change | Approval | Date of Issue |
|---|---|---|---|
| **v1.0** | Published final version. | | June 2021 |
| **v1.1** | NCFE rebrand | | September 2021 |