Speech and Language Talk Tools Update Summary Report

Name: Jennifer Mc Kitterick	**DOB: 11.12.94**
Address: 126 Julian Road, West Bridgeford, Nottingham, NG9 2QR	

Jennifer has been re assessed across two sessions using the Talk Tools assessment and therapy hierarchies on the following dates; 13th January 2011 and the 19th January 2011 at school. The second session involved observing Jennifer at lunch time and using aspects of the Talk Tools approach to prepare for lunch time eating.

Oral Motor skills and Talk Tools assessment findings

Jennifer has made extremely encouraging progress using the Talk tools approach with Jos and Josie (Jennifer's NHS SALTS) at school and with Melanie (ITS SALT) within the clinic. It is evident that the twice weekly practice as a minimum is having the desired effect on improving her oral placement skills.

Toothette:

Jennifer appears to accept the toothette much more readily with less sensitivity. She will allow the toothette to be placed on her hard palate and between her lips and teeth on the bottom and top jaw.

Using the toothete prior to dinner time, appears to prepare Jennifer's muscles for eating, making her more aware of lip closure to reduce liquids spilling form her mouth.

Bite Blocks:

Previously I had suggested that Jennifer starts on bite block 2 holding it in all three positions for 15 counts with resistance. This would need to be carried out at least once a day Jenifer is now able to achieve holding bite block 3 in the left and right side for 15 counts and is therefore ready to move onto bite block 4 and work her way up to 15 counts. Jennifer struggles to achieve holding the bite block across her jaw, therefore she should continue with bite block 2 in this position.

Integrated Treatment Services
The Stables
Brooklyn House
44 Brook Street
Shepshed
Leicestershire
LE12 9RG

T 01509 600 646
F 01509 600 646
E info@integratedtreatments.org.uk

www.integratedtreatments.org.uk

It is evident that Jennifer's jaw is really strengthening as she is dryer around the mouth, she is better at bubble blowing (hence being able to isolate her lip movement) she is also able to straw drink with more success, I shall go on to discuss.

Bubbles:

Jennifer has made significant progress on the bubbles hierarchy . Previously Jennifer was advised to use the popping on lips, whispered 'hoo' sounds and then moving back to independent blowing.

Jennifer is able to blow 15 bubbles off the wand. During the assessment we turned the wand to the 'normal' blowing pattern and Jennifer now blows the bubble through the wand with more controlled air stream.

Jennifer now needs practice as blowing the bubble with control over a distance of an arms length to support her breath stream for speech and eating.

Straw drinking:

Jennifer has be re assessed using the honey bear cup and straw and recessed cup in the direct therapy session, she was also observed drinking at lunch time.

Jennifer is much more able to carry out therapeutic straw drinking using the honey bear and straw number 1. She is able to draw liquid up the straw, without the need of the adult to squeeze the bear. Jennifer now needs to complete 15 separate sips taking the straw away from her mouth between each sip and without the adult squeezing the bear.

Jennifer also needs practice using her recessed purple cup. With this cup Jennifer still has a tendancy to hold the cup in mid air between her lips rather than resting the cup on her lip. This is also true of Jennifer's drinking style when using a normal cup at lunchtime.

I would say there are some behavioural aspects to consider with Jennifer around drinking. Jennifer likes the impact of pouring liquid over, it has been noted that when bubbles or drinking has been carried out, Jennifer is likely to try and spill the fluid.

I feel Jennifer should ONLY be drinking out of the honey bear or the recessed purple cup. School report there was a shortage of these accessible throughout the day, so we have ordered more to ensure that Jennifer ONLY uses these two cups at break, lunch time and drinking throughout the day.

Jennifer does need to take part in some therapeutic drinking during her direct therapy session however, she needs to be taught to rest the cup on her bottom lip and not in mid air, she also needs help to monitor when she has taken enough liquid, she needs reminding that her chin needs to be UP and her lips CLOSED. Much of Jennifer's drinking and eating skills, needs verbal prompts to remind her what to do, some work with a mirror in front of her will also help.

<u>Horn hierarchy:</u>

Jennifer has not been using the horns in her therapy sessions to date, however given the great progress she has shown, we would like to introduce the horns. Josie already reports that horn 1 for 15 counts is

achievable therefore she should move through each horn so that she can blow 15 stop start blows on each in order.

Tongue depressor between the lips:

Jennifer really still struggles to bring her lips together with strength in this exercise to hold the tongue depressor in count for 15 counts. She needs the adult to hold her lips into position so that she feels the sensation of the correct placement. I have suggested holding her lips in place for 15 counts each time – really ensuring her lips are protruding around the tongue depressor. She then needs to be asked to hold on her own for 1 count. This should be built up until she can achieve 15.

Eating and drinking:

During lunchtime Jennifer was prepped before eating using the z vibe and the toothette. Jennifer appeared to really benefit from her muscles being 'warmed up' by vibration prior to eating.

She does however need lots of accurate verbal prompts and routines to help her eating become a tidier eater. Jennifer needs prompts such as chin up and lips together adding to her eating and drinking plan. She also needs adult support initially to assist placing placement of her recessed cup on her lower lip, so that she does not hold the cup in mid air and pour it down her. Jennifer needs to generalisation her newly learnt strategy (dabbing her chin dry) across lunchtime, she has mastered this skills well across other parts of the day. Jennifer should not attempt putting more food of drink to her lips if her chin is wet, the reason being is that she will not feel when food is spilling out of her mouth.

Finally Jennifer would benefit form carrying out some therapeutic eating and drinking. The drinking tasks would involve using the honey bear and recessed cup and completing 15 accurate sips without compensatory movement. This repetitive techniques helps the muscles form a motor plan and also increases strength in the oral placement muscles.

A 'slow feed' technique can be trialled with Jennifer, this involves cutting up food such as cheese on long strips and encourage Jennifer to use a munching movement on her back molars to encourage the chew. Jennifer is still using a very immature bite and mainly ploughs food in to trigger a swallow rather than chew food until it is ready to swallow. This puts Jennifer at risk of choking. Jennifer could work on the slow feed technique in therapy sessions and generalise this to her lunchtime routines.

Other areas' of development:

Jennifer has attended the clinic to work with another ITS therapist Melanie. Jennifer has generally responded well to these sessions, aside from her last session where she has an episode of negative behaviour which has led to Jennifer being risk assessed as unsafe to access the clinic for therapy as things stand.

Melanie is happy to continue to support this work at home and guide staff and parents around the talk tools programme at home.

Aspects to note is that Jennifer is still experiencing difficult periods of behaviour at home. These aspects are being addressed as part of a psychological behavioural support plan led by Nigel Colbert.

From a speech and language point of view, it has been noted, that Jennifer needs very clear boundaries, she must understand that the therapist sets these boundaries and that they are fair and the activities have clear benefits for Jennifer.

We always explain what the activities will help Jennifer to achieve, e.g independent eating, more successful talking. Jennifer needs to be given a level of information to help her make 'sensible choices' to help her in her future. It is dangerous to the therapist when Jennifer is given the powers of control – e.g deciding where the therapist should sit etc, as Jennifer may already feel vulnerable at these points and therefore needs a strong and confident therapist to outline the plan.

Jennifer has apologised if her behaviour ahs been inappropriate to adults at any point, this is usually towards the end of the session. She is very keen to want to continue working. It is crucial to the therapists working with Jennifer, to be brought up to speed on her day so far, so that we can recognise any triggers and be mindful of the levels of demands placed on her during that session.

I personally feel that Jennifer responds better to direct therapy through the structure of the school day. I feel that it may be more appropriate to train up carers and parents through visits into therapy sessions taking place at school and through the use of video footage without Jennifer present. If we can build confidence in this way, Jennifer may come to accept therapy outside of school.

It is very possible to include functional aspects of therapy into her every day routines rather than delivering therapy as a specific programme of work carried out each day.

Conclusions and recommendations:

Jennifer has responded really well to the structure of the tasks that Talk Tools offers. This enables her to build better attention and listening skills as well as support behaviour modification – engaging herself in a task which she might find difficult and would otherwise avoid. It has been an excellent approach to build a good rapport with Jennifer, building trust and cooperation.

The Talk Tools approach believes in assimilating the experiences used through oral -motor exercises and feeding to develop speech sound patterns and good oral motor skills. This means that by developing the oral motor skills used in good feeding we can go on to develop better skills in speech production.

Jennifer feeding continues to be quite slow and messy with poor oral motor skills to achieve good chewing, tongue lateralisation for clearing food and poor lip protrusion and tongue retraction for drinking. By working on the advised exercises it is hoped that we can improve Jennifer's tidy and more independent eating skills as well as produce greater clarity in her speech production.

I would suggest the following updates to her Talk Tools therapy programme.

- Bite block – no 3 15 counts on L and R side. Bite block 2 up to 15 counts across the front teeth
- Bubbles blowing for a distance of 'arms length' with the bubble wand in the up right position.
- Tongue depressor – holding for 15 counts with adult support and for 1 count on her own
- Straw drinking – up to 15 sips out of the honey bear with straw 1 and 15 sips with the recessed cup
- Slow feed – 15 'munch bites' on a piece of 'Baby Bell' cheese cut into strips, parents to send these into school on therapy days in addition to her one she eats for pudding.
- Associating the above movements to the relevant speech sound to support transition of these into speech (refer to the talk tools homework book)
- Horn 2 for 15 blows, using stop start technique.

The re assessment session has been recorded and emailed to all those professionals involved.

I would be more than happy to discuss in further details with parents, teaching staff and MDT colleagues the details of this report.

An updated costing plan has been sent to Jennifer's case manager to agree ongoing intervention at home and at school from myself and Melanie.

Signed: Sarah DAvis 28.01.11

Sarah Davis
Independent Speech and Language Therapist
Integrated Treatment Services