

**‘I do the best I can’: An in-depth exploration of the aphasia management pathway in
the acute hospital setting**

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ABSTRACT

Purpose: While research has begun to explore the management of aphasia across the continuum of care, to date there is little in-depth, context specific knowledge relating to the speech pathology aphasia management pathway. This research aimed to provide an in-depth understanding of the current aphasia management pathway in the acute hospital setting, from the perspective of speech pathologists.

Method: Underpinned by a social constructivist paradigm, the researcher implemented interpretive phenomenological method when conducting in-depth interviews with 14 Australian speech pathologists working in the acute hospital setting. Interview transcripts and interviewer field notes were subjected to a qualitative content analysis.

Results: Analysis identified a single guiding construct and five main categories were identified to describe the management of aphasia in the acute hospital setting. The guiding construct, *First contact with the profession*, informed the entire management pathway. Five additional main categories were identified: *Referral processes*; *Screening and assessment*; *Therapeutic intervention*; *Educational and affective counselling*; and, *Advocacy*.

Conclusions: Findings suggest significant diversity in the pathways of care for people with aphasia and their families in the acute hospital setting. Additional support mechanisms are required in order to support speech pathologists to minimise the evidence-practice gap.

The provision of speech pathology intervention for people with aphasia in the acute hospital setting has the potential to result in improved longer-term communicative outcomes [1], an increased sense of satisfaction for people with aphasia with regards to their healthcare [2], an improved ability to have healthcare needs met, and a reduction in hospital-based adverse events [3]. These strong rationales, in combination with advances in the awareness of potential clinical applications of neuroplasticity principles [4] and a growing organisational focus on the implementation of evidence-based practice (EBP), have resulted in an increased interest in the management of aphasia in the acute phases of recovery.

Exploring the literature in relation to the management of aphasia in the acute hospital setting is, however, not without its challenges. Within the aphasia literature terminology such as ‘acute phase’ or ‘early stage’ tends to be indicative of time post onset (i.e., 1-3 months post onset), and as such does not take into account the location of services being provided (i.e., the acute hospital setting or the rehabilitation ward) [5]. This acts as a hindrance to understanding practice as barriers to the provision of aphasia management that may not occur in other settings may exist in the acute care hospital.

Clinically, two distinct treatment paradigms exist in relation to the management of aphasia. These paradigms are informed by the International Classification of Functioning, Disability and Health (ICF) [6]. *Impairment-based approaches* refer to intervention targeting the Body Functions and Structures section of the ICF. Approaches to intervention addressing the Activity and Participation components of the ICF are most often described by speech pathologists as *functional approaches*. Within the available literature, two distinct schools of thought regarding the management of aphasia in the acute hospital setting can be identified: those who advocate for the provision of information, support, and counselling by ‘consultant’

speech pathologists [5,7-9], and those who advocate for very early, impairment-based intervention [1,10,11]. Those advocating for a consultative role for speech pathologists believe that ‘education, counselling, and compensatory efforts to maximise communication are primary goals’ [5] in the acute hospital setting. They use the anticipated positive effects of spontaneous recovery, and a lack of feasibility of impairment based intervention in the majority of cases, as a rationale for this approach. Conversely, those supporting very early impairment-based interventions cite the potential for therapy-induced recovery in line with the application of the neuroplasticity principles of ‘use it or lose it’ and ‘use it and improve it’ to aphasia rehabilitation [4]. Much of the research literature in this area to date is based upon expert opinion, and reflects the ‘different beliefs about what the goals of assessment and care should be’ [5]. It is clear that research questions in this area remain [12].

Recommendations for best practice in the management of aphasia in the acute hospital setting

Speech pathologists report that clinical guidelines are the main source of research evidence used to guide their aphasia management [13]. Derived from a critical, systematic evaluation of all relevant literature, clinical guidelines provide a series of ‘best-practice’ statements to facilitate collaborative clinical decision making within specific areas of healthcare practice [14]. Rather than stipulating the timing of specific interventions, clinical experience and reasoning must be utilised to ascertain the relevance of a specific recommendation at any given time, based on the clinicians’ understanding of the practice context and the patient’s wishes. Despite this, some concerns have been raised in relation to the rigid implementation of guidelines without consideration of the broader patient and contextual factors [15].

Internationally, a range of clinical guidelines which describe the management of aphasia exist [e.g., 16,17-20]. In Australia, the Australian Aphasia Rehabilitation Pathway (AARP) [21] was also recently made available. These guidelines represent the breadth of speech pathologists' practice in the management of aphasia in the acute hospital setting, and across the continuum of care. A systematic evaluation of the quality of guidelines exploring aphasia management available at the time has suggested significant variability in the guideline development process, and also in the scope of the recommendations provided within the guidelines [22]. While the majority of synthesised research included in current guidelines garners only a low-level grading for the aphasia-related recommendations, it is important to acknowledge that the strength of this grading is not necessarily reflective of the clinical importance of the recommendation, but rather a reflection of research design and the stage of research development in the area [18].

A number of factors, however, have been reported to influence the implementation of clinical guidelines. In the first in-depth qualitative study exploring stroke guideline implementation by speech pathologists, Miao, Power and O'Halloran [23] indicated that speech pathologists considered the perceived relevance of the guidelines to their workplace, the degree of change required compared to the available resources, and their personal motivation to make change in their clinical practice when attempting to integrate recommendations into practice.

Explorations of current practice in acute aphasia management

Despite the number of guidelines available, little is known about current aphasia management practices in the acute hospital setting (i.e., what specific services and intervention are provided by speech pathologists), or the clinical decision making that underpins the

management pathway. A number of issues make understanding current practice in aphasia management difficult. These include:

- (a) Some of the existing literature focuses on a single practice domain, such as assessment [24], and as such does not provide a comprehensive overview of current practice;
- (b) The rapidly changing healthcare climate means that existing literature is likely to become rapidly outdated [e.g., 13,25];
- (c) Data about aphasia practices collected from clinicians across the continuum of care [e.g., 13,25,26] may not represent the service provided by clinicians working in the acute care setting; and,
- (d) Survey data alone is insufficient to allow for a comprehensive understanding of the reasons underlying the clinical decisions which underpin the current management pathway.

Current data about aphasia practice in the acute hospital setting is, however, in agreement that the amount of time devoted to people with aphasia in is incongruent with best practice recommendations [e.g., 25,27,28-30].

Despite these limitations, the national survey by Rose et al. [26] does provide some data regarding current aphasia practice across the continuum of care. The researchers sought to explore current aphasia rehabilitation practices in Australia, and did include data collected from speech pathologists working in the acute hospital setting. The findings reported that dysphagia was the main caseload for 89% of clinicians working in the acute hospital setting. Cognitive neuro-psychological, social, and group approaches to the management of people with aphasia were considered less appropriate in the acute phase of care. Time restrictions,

perceived limitations on scope of practice, and the expectations of family members were also reported to shape the service provided to people with aphasia in acute care settings.

Pertinently, responses to open-ended questions by clinicians in the acute hospital setting indicated the dissonance experienced by some clinicians in relation to the de-prioritisation of aphasia services.

While this provides us with some preliminary data regarding current practice, a greater understanding of current practice is required in order to support speech pathologists working in this field, within this context. The need for current data is especially important in the context of an evolving healthcare system, in which greater demands are placed on clinicians' time within the acute hospital setting and clinicians' time is therefore prioritised. In order for clinicians to be able to provide effective and efficient interventions which meet the economic needs of the healthcare organisation and the needs of people with aphasia and their families, whilst also providing professional satisfaction for the speech pathologists, a cohesive picture of current management approaches which explores the underlying decision making is essential. Hence the aim of this study is to understand current aphasia management practices by speech pathologists who work in the acute hospital setting.

METHODS

Research purpose

This research forms part of a larger qualitative study exploring the experience of aphasia management in the acute hospital setting from multiple perspectives. The aim of this particular study was to understand the current acute aphasia management pathway from the perspective of speech pathologists.

Research paradigm and strategy

A qualitative research approach is essential when a deep and detailed understanding of a complex phenomenon is sought [31]. In addition, this approach is supported when little is known about the topic under investigation [32]. As such, within this study qualitative research methods were utilised as a means to document and describe the lived experience of acute aphasia management from the speech pathologists' perspective. A social constructivist paradigm provided the foundation for this study. Social constructivism relies on the use of inductive methods within naturalistic settings to understand experience through the perspectives of individuals [32-34]. An interpretive, or hermeneutic, phenomenological research strategy was implemented. This choice is supported by two main arguments. Firstly, it is consistent with the aims of the research in that it allows for the development of a deep understanding of a particular phenomenon from multiple perspectives [35]. As the purpose of this research is to understand the aphasia management pathway in the acute hospital setting from the perspective of speech pathologists, the selection of a research strategy that allowed the researcher to move beyond description in attempt to understand underlying perceptions was considered appropriate. Secondly, interpretive phenomenology is consistent with the underlying paradigm, with both acknowledging the role of the participant, researcher, and their personal experiences in the co-construction of knowledge [33,36,37]. Ethical approval was granted by The University of Queensland's Behavioural and Social Sciences Research Ethics Committee prior to the commencement of this research.

Participants

Speech pathologists currently working with (or having recently worked with) people with post-stroke aphasia in acute hospitals across Australia were invited to participate in this study. Participants were recruited through a range of sources in order to appropriately sample

the target population. Recruitment was initiated through the distribution of expression of interest forms: (a) at meetings, forums, and conferences; (b) through listservs targeting speech pathologists practising or interested in the management of adult clients; and, (c) to the speech pathology departments of hospitals reported as having a stroke care unit or greater than one hundred stroke admissions a year. A total of 36 speech pathologists expressed interest in participating in this research. Those who expressed interest in the research were solely from the eastern states of Australia: Queensland, New South Wales, Victoria, and Tasmania. A purposive, maximum variation sampling [38] technique was utilised in order to achieve variation in participants across: (a) duration of clinical experience; (b) regional and metropolitan workplace settings; (c) private and public sector workplace settings; and, (d) the presence or absence of an acute stroke unit (ASU) in the participant's workplace setting. Meaningful selection of participants in order to provide adequate data to elucidate the phenomenon of aphasia management was central to the selection of participants, rather than attempts to create a representative sample [38] or generalise the information [33]. As such, no set formula was applied to determine sample size in this study [38,39]. A flexible approach to sampling was used, without pre-established and rigid knowledge of the number of participants to be recruited [32]. The sample size was influenced by our desire to interview speech pathologists across different variation criteria, and to approach a sense of saturation. Fifteen speech pathologists were selected to take part in this research; however one speech pathologist's interview data was excluded when it became known that she was not currently practising (and had not recently practised) in an acute hospital setting. Interview data from 14 speech pathologists was included in the final analysis. Participant characteristics are illustrated in table 1. Diversity in state of clinical practice was also achieved, with the sample including clinicians from New South Wales ($n=3$), Queensland ($n=3$), Tasmania ($n=1$), and

Victoria ($n=7$). All participants were allocated a pseudonym for the purposes of the research and all subsequent reporting.

Table 1. Participant characteristics ($n = 14$)

Participant^a	Duration of clinical experience as a speech-language pathologist	Setting of clinical role	Presence of acute stroke unit in hospital of employment	Sector of employment
Ada	< 5 years	Metropolitan	ASU present	Public
Amy	< 5 years	Metropolitan	ASU present	Public
Beth	< 5 years	Non-metropolitan	ASU present	Public
Celeste	< 5 years	Metropolitan	ASU present	Private
Danielle	>15 years	Metropolitan	ASU present	Public
Josie	< 5 years	Metropolitan	ASU present	Public
Karen	5-15 years	Metropolitan	ASU present	Private
Leah	5-15 years	Metropolitan	ASU present	Public
Mae	>15 years	Metropolitan	ASU present	Private
Monica	5-15 years	Non-metropolitan	No ASU	Public
Rachael	>15 years	Metropolitan	ASU present	Public
Stella	5-15 years	Metropolitan	No ASU	Public
Tess	5-15 years	Non-metropolitan	No ASU	Public

Viv	< 5 years	Non- metropolitan	ASU present ^b No ASU ^b	Public ^b Private ^b
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^a Pseudonyms were used

^b Clinician worked across two clinical settings

Research method

Methodological congruence was achieved through the selection of a research method which philosophically aligned with the underlying research paradigm and strategy. Semi-structured, in-depth interviews engage the participant in conversation to elicit their understanding and interpretations, by reflecting on their lived experience [40-42]. In order to generate discussion about the speech pathologists' experience of working in acute aphasia management, speech pathologists were instructed to *'Tell me about your experiences of working with people with aphasia and their families in the acute hospital setting'*. Additional topics probed include: the standard speech pathologist management pathway for people with acute post-stroke aphasia; the influences on decision making in acute post stroke aphasia management; and, the barriers and facilitators to achieving evidence-based practice in acute post stroke aphasia management. A broad topic guide was used, however the interviews were characterised by flexibility in the order and the wording of questions, allowing the researcher to follow the participant's lead. The interviews were recorded on a digital audio recorder, and were later transcribed verbatim by the primary researcher or an independent transcription professional.

Data analysis

All data were stored and managed within NVivo 9 [43]. The data were analysed using qualitative content analysis [44]. This allowed for systematic analysis of the data [45], during which the categories and their content were derived inductively from the data [44]. Consistent with phases of inductive content analysis described by Elo and Kyngäs [44], following a

period of open coding, categories were grouped together under higher order headings. These were then reduced into broader, higher order categories, at which point each category was named using content-characteristic words.

Rigour

Within qualitative research, the rigour of the methodology can be established by the degree to which the study demonstrates credibility, transferability, dependability and confirmability throughout the research process [46]. Within the current study, a process of *peer checking and debriefing* was used. This allowed for the discussion of transcripts and emergent categories between all authors to ensure interpretations being made were reasonable and were strongly linked to the source data. Debriefing sessions were also an opportunity for the research team to employ reflexivity, acknowledging the potential influence of their prior clinical and research experiences on the process of data generation and analysis and identifying any sources of potential bias. In addition to this, an *audit trail*, containing documentation of theoretical, methodological and analytic choices, was kept by the primary researcher. A record of evidence consisting of the raw data, products of data analysis, and products of data synthesis form the audit trail in this study. Additional strategies included *member checking* of transcript accuracy, whereby interview transcripts were sent to participants and amendments to or clarifications of content and/or meaning could be provided prior to analysis. Moreover, the *presentation of preliminary findings* at international conferences was used to ascertain the resonance and value of the findings to researchers and clinicians. Finally, rigour is supported in the reporting process (demonstrated in this manuscript) through the use of thick description [32], illustrative quotations from the interview transcripts, and a comparison of the findings with the existing research literature [31].

RESULTS

A single guiding construct and five main categories were identified to describe the management of aphasia in the acute hospital setting. The guiding construct, *First contact with the profession*, was identified as it informed the entire management pathway. Five additional main categories, related more specifically to the tasks undertaken as a part of acute aphasia management, were identified: *Referral processes*; *Screening and assessment*; *Therapeutic intervention*; *Educational and affective counselling*; and, *Advocacy*. Each of these categories is discussed below.

Guiding construct

‘What [are they] gonna think of me in a year?: First contact with the profession

A number of speech pathologists who participated in this research indicated that they were acutely aware that, as they worked in the acute hospital setting, they may be the first contact that people with aphasia and their families had with the profession.

‘I always kind of have in the back of my mind I am the first person that’s gonna talk to them, that is going to talk to them about it. And I always wonder what, what they’re gonna think of me in a year when they’re actually, they’ve improved’ (Josie)

This responsibility was weighty, as it had the potential to establish the long-term perception that patients held of the profession. Perhaps in response to this, the speech pathologists in this study felt the need to build strong relationships and provide hope, but also temper expectations.

Relationship building is important

Possibly as a result of the desire to create a positive impression of the profession, the participants in this study placed emphasis on relationship building with people with aphasia and their families. Notably, equal if not greater emphasis was placed on building relationships with the family members. Ada reports ‘...*taking those initial few sessions to really spend time with the family, really try as, as much as you can to, to build rapport and relationship with that patient*’ .

Giving hope

Instilling hope in people with aphasia and their families was articulated as an explicit goal of acute speech pathologists by a number of participants in this study. Beth articulated the importance of this, suggesting that using the acute hospital stay as a time to build motivation and hope was an essential element to prepare people with aphasia for the ‘*hard work*’ essential to moving towards living successfully with aphasia.

‘In the acute phase you spend just that time building rapport for that little bit before you push them to do too much hard stuff. Um, and more of that recognition of what’s happened with their communication before you actually start. And just saying to them, “You know, we can do some work around this,” and that sort of thing. There’s hope.’

(Beth)

Participants described that clinically, this manifested in discussions regarding the potential for linguistic recovery, but also in discussions of the nature of communication. Rachael reported that ‘*one of the first messages I usually try and give to the families...is that, you know, “You will still communicate. You know, there will still be communication”*’, alluding to the multimodal nature of communication. The importance of instilling hope in people with aphasia and their families is illustrated in Rachael’s words: ‘*Hope, I think, is the key*’.

Tempering expectations

Some speech pathologists saw it as important to balance the provision of hope with the provision of realistic expectations regarding linguistic recovery post-stroke. One less experienced speech pathologist in particular found this a difficult challenge, saying, *'I think there's always those, um, patients who, unfortunately, might have too much hope. And it's always, you know, so distressing to kind of, bring them back down...just acknowledging that, might not get much better but it could get a bit better'* (Josie).

In addition to tempering the expectations of recovery, the need to moderate the expectations of service delivery was also considered to be an important role. As the first point of contact with the profession, these speech pathologists also felt that it was their responsibility to set up realistic expectations for the person with aphasia and their family. Firstly, it was perceived as being important that the acute speech pathologists provided a clear idea of their capacity to provide service to people with aphasia in the acute hospital setting. This was especially important for speech pathologists who did not feel their service was consistent with best practice recommendations, who felt it important to *'just mak[e] patients and families aware that, you know, research would say that I should be seeing you every day or thereabouts and I would like to, but we're short staffed and so that's not gonna happen'* (Leah). In addition to this, one speech pathologist reported that she tried to avoid *'setting the bar too high'* in terms of the service that would be provided in the rehabilitation setting, suggesting that this would be *'unfair to the rehab therapists'* (Josie). This was in stark contrast to a number of other speech pathologist participants who reported that people with aphasia were much more likely to get a service which approximated the recommended intensity in the rehabilitation setting.

Main categories

Primarily, it is important to note that there was no ‘standard’ pathway for the management of aphasia across the participants in this research project. Even clinicians practising in the same Australian state did not share common management practices. Each participant described a unique pathway, with emphasis placed on different roles played by the speech pathologist in this setting. The lack of consensus regarding the ‘correct’ management approach was highlighted by one participant, who reported, *‘I guess I’ve been, um, it’s been tossed around a little bit to try and come up with the best pathway for acute management. Um, personally tossing up, “Oh, it is more important to do the education or the assessment, or is the assessment even relevant?” Um, so it has been a bit tricky, actually. And I...I don’t think that I have answer’* (Celeste). Despite these differences, some commonality was evident, and the following categories were derived from these common elements.

Referral processes

The referral processes for people with aphasia in acute hospital settings varied greatly between settings. A continuum of referral mechanisms was observed. At one end of the continuum, a blanket referral for speech pathology assessment of communication was made in order to ensure that *‘every patient who comes in with a TIA or CVA gets screened for communication problems’* (Amy). This method of referral was most common in hospitals in which an acute stroke unit was present. At the other end of the spectrum, people with aphasia were at times not referred to speech pathology until the point of discharge, at which time speech pathologists were told, *“Oh, this patient’s going home but they’re still having some word finding difficulties, can you see them?”* (Leah). Delayed or inefficient referral

mechanisms were more commonly described in the private sector, or in hospitals without acute stroke units.

Most speech pathologists who participated in this study indicated that referrals to speech pathology in the acute hospital setting are often generated in response to dysphagia, rather than communication impairments. Leah reported that this was due to the perceived urgency of dysphagia management, suggesting that *'the referral will usually happen because their swallowing needs assessing. You know, urgently'* (Leah). For referrals to be generated for aphasia, a marked aphasia – easily recognised by staff less familiar with communication impairments – needed to be present in some settings. *'It would depend on their severity of their, um, aphasia as to whether we'd get called down or not'* (Tess). It was suggested, however, that regardless of the reason for referral, receiving timely referrals was important and allowed early access to people with communication impairments. In Stella's words, *'we are very lucky here that our nursing staff...refer all the strokes to us, but from a swallow point of view, from a swallowing perspective. But at least that's a referral, so that means that we can then see them, and we still will screen them and if need be they'll get the input for their aphasia that they need. So – we are lucky in that way'* (Stella).

One speech pathologist's experience of different referral mechanisms led to her reflecting on the potential influence that these have on the timeliness and amount of speech pathology intervention able to be offered to people with aphasia in the acute hospital setting.

'At [metropolitan public hospital] they have an alert, so we all know that a stroke patient has come into the hospital into ED and I can go down as soon as I get that page. Whereas, um, at [outer metropolitan public hospital] or at [metropolitan private hospital], um, I won't know that there's a stroke patient here until the

consultant refers me. So I'm, in terms of getting acute aphasia management, I might miss that really important first couple of days and maybe only get referred later down the track.' (Celeste)

While some expressed frustration at their current referral mechanisms, implicit in their responses was a perceived inability to directly affect change in this area and an acceptance of current practice.

'We need to know what's wrong with you so we can help you': Focus on screening and assessment of aphasia in the acute hospital setting

The accurate assessment of aphasia was seen by these speech pathologists to be the cardinal component of speech pathology intervention in this setting, with every participant describing a mechanism for identifying the presence and severity of aphasia. Rachael reported that *'obviously'* she needed to do an assessment with the patient, and Viv characterised assessment by saying *'the main thing that we want to do is assess our patients right, you know correctly'*. Screening and assessment was considered by the participants to be of importance for a number of reasons, including: (a) to provide diagnostic information; (b) to provide a structure in which to discuss the patient's function with their families; and (c) to determine suitability for rehabilitation planning and facilitate discharge planning.

Throughout the interviews there was little, if any, differentiation between the terms *screening* and *assessment*, with many of the participants using the terms interchangeably. Participants were, however, keen to distinguish their assessment from assessments or screenings undertaken by other professions, such as the medical team, in terms of content, depth, and the rationale for undertaking the assessment.

The method for assessing language in the acute hospital varied significantly across clinicians. By far the most widely described means of screening or assessing communication in people with aphasia within the acute hospital setting was an ‘informal communication screener’. This terminology, although not consistent across participants, was used to describe a tool which had not been validated or standardised, and – for the most part – had been designed ‘in house’ as a conglomeration of sub-tests from existing, formalised language assessment tools. Informal screening tools were described as being able to be modified without concern, and also allowed clinicians *‘to assess what’s happening across modalities’* (Rachael). This informal approach was strongly advocated for by some, who suggested there would be *‘certainly no formal assessment with the patient at that stage’* (Tess). Rather, their preference was to *‘get that overall feel for [the person with aphasia’s] language’* (Amy), while simultaneously protecting the person with aphasia from the experience of failure which may accompany formalised assessment and conserving precious time. The ability to use a less structured, more informal approach to assessment was described as a skill which evolved with clinical experience. Viv suggested her capacity to use informal conversation to provide an assessment had grown, and contrasted this to her previous reliance upon structured, written tools. This notion was supported by Josie, a newer clinician, who described her process of making the change from structured to informal methods.

‘Maybe we’ll just try to have a chat about their garden or something. I think going about the assessment in a different way. I think – I’ve started trying a lot more of that’
(Josie)

A preference for formalised screening tools was expressed by some participants who felt that the standardised nature of the screening homogenised the process, provided a structure upon which to provide education, and was a baseline measure to which outcomes can be compared.

'I always like to do a standardised assessment with everybody, and whether that's a screening - um, the Frenchay or the Sheffield - I feel like I like to have a formalised assessment for everybody rather than, um, an informal questions type thing. So I do one for everybody and then I have something that I can tell the family or that I can do a baseline for, so I know that I've got – that information' (Celeste)

A complete, formalised language assessment in the acute setting was considered essential for some clinicians, like Karen who recounted, *'I'll do a formal language assessment, even before they get down to rehab, just so I know where I'm going. I don't wait for them to go to rehab to do that stuff'*. Josie described the potential to undertake a formalised language assessment, but her language was littered with conditional terminology: *'...if it was the right patient, um...and if there was not that many people on the caseload, I could definitely start one'* (authors' emphasis). In contrast to this, Tess reported that there would never be a circumstance in which she would administer a formalised language assessment in the acute setting as *'the time to do a full assessment on [people with aphasia] doesn't exist'*. In addition to this, rapid changes in communication presentation of the person with aphasia, short length of stay, environmental design and the patient's linguistic background were cited as reasons for not undertaking formalised language assessment.

The assessment tasks described were mostly focused on the identification of deficit in the individual with aphasia. The tasks described by participants, including object naming, single

word comprehension, and repetition, had an impairment-based focus. Some described a preference for impairment-based assessment as *'it's nice to have something that's a bit more concrete'* (Rachael). Functional assessment of communication was considered by most to be secondary, something that *'goes alongside'* (Rachael) the impairment-based assessment.

While the value of functional assessment was recognised by some, such as Ada who asked, *'What can we put in place to make this person um, able to get their needs and wants across to the nurses and their family the best they can?'* there was little discussion of how these evaluations were undertaken.

Speech pathologists indicated the importance of communicating the assessment findings and recommendations, and placed emphasis on the transmission of this information to nursing staff. Participants depicted a range of different explicit communication strategies, including bedside signage, documentation in the medical record, and direct interaction with nursing staff. Leah contrasted the way in which the findings of a swallowing assessment were communicated with the way communication recommendations were communicated, saying:

'[Following a dysphagia assessment] we put up a sign about the beds, saying 'This is what diet they're on'. But we don't put a sign saying, "This is how they communicate with this person. Please put my hearing aid in, please speak Russian to me, please write down key words". You know. From a total communication point of view, I don't think we're doing that well.'

In addition to this, speech pathologists discussed the implication of assessment findings not being understood or adhered to. This experience, it was suggested, was deeply frustrating for the speech pathologist.

'It's frustrating when...you're with someone else but you can see your stroke patient over there and the nurse doing an awful interaction with them, and you just, it is – it's

really frustrating' (Stella)

'I do the best I can': Approaches to aphasia intervention

Goal setting for therapy

Notable in the transcripts of these interviews was a paucity of discussion surrounding goal setting. Little emphasis was placed on the process goal setting in the acute hospital setting, and the difference in goal setting in the acute and the sub-acute sectors was accentuated. Amy suggested that in the acute setting, *'goals are - sometimes I feel like they're not quite so individual for the patient but just sort of general goals'*. Clinical experience across the continuum of care was reported to influence goal setting in the acute hospital setting, with Stella suggesting that as a result of that experience she could *'see where that line is of "what they need to be doing on an acute ward", and "what they need to be doing once they get to rehab and they, they're trying to get back to their old way of life"'*. The language used in the discussion of goal setting with people with aphasia tended to lack inclusive terminology, suggesting that the process was clinician- rather than patient-driven. For example, Josie reported that *'I suppose I try to set them what I think could be attainable goals'* (authors' emphasis). Of the few participants who discussed goal setting, the setting of small, achievable goals was described as being important in the acute hospital setting, as was preparing the person with aphasia for the sort of goals which may be addressed in the rehabilitation setting.

Provision of therapy

Variation between participants was observed in relation to the provision of therapy in the acute hospital setting. Very few participants reported providing daily intervention to people with aphasia in the acute hospital setting. Clinicians who did provide intensive therapy tended to be more experienced, and employed in clearly delineated roles where their expertise in

communication disorders was recognised by both the speech pathology and multidisciplinary teams. One such clinician provided insight into her personal motivation to provide therapy in the acute hospital setting, suggesting that she didn't want to focus on assessment alone and was thus driven to provide therapeutic intervention. The more dominant narrative, however, was one of not being able to achieve this in the context of competing priorities, as described by Tess:

'If they're straight aphasic with nothing else, because of prioritisation and, um, because of just your time limitation...the time to be seeing them for daily therapy doesn't exist and it's a huge gap. And, it frustrates me because I like [laughs] working with aphasia and I think there's so much potential for things to be done on the acute ward' (Tess)

Participants also suggested some alternatives to providing direct therapy to people with aphasia in the acute hospital. The first of these was 'being available'. Josie indicated that *'being available is my key thing...even if I can't do anything for them, at least I can talk to them about it, or, and be honest'* (Josie). The other alternative was a 'communication check', which was characterised by participants as a brief contact in which an informal review of the person with aphasia's language was undertaken.

Viv recognised that not providing direct therapy represented an evidence-practice gap in her clinical work, and expressed concern that *'the evidence is saying, you know, a couple of hours [of therapy] a day, well...I really can't get that done on the acute site...So I do the best I can'*. A dissonance created by the inability to provide intervention as level consistent with best-practice recommendations was reported by many of the speech pathologists participating in this research.

Underlying therapeutic paradigms

While a difference in underlying perspective was noted in the responses of the participants, the paradigms underpinning their practice were not discussed explicitly by the participants in this research. Participants touched on intervention across the ICF [6] domains, however discussion of the integration of these components was limited.

These speech pathologists, for the most part, described taking an impairment based approach: *'I feel, um [pause] it's very impairment based. I don't do a lot of functional... it just doesn't seem as relevant in that acute stage'* (Karen). A variety of interventional modalities – including tablet applications and worksheets– were described as targeting the language impairment of the person with aphasia. The use of impairment-based worksheets was the most widely described approach to intervention, although the limitations of this were discussed. Worksheets were generally required to be completed independently, or with the support of family if they were present. Stella suggested that the intensity of rehabilitation could be increased if *'it's exercises that are easy to grab, and easy to give to someone else to do'*. Of concern, one less experienced clinician suggested a lack of critical thinking in the provision of impairment-based therapeutic activities, reporting *'I'll choose something or maybe one or two things, just from a folder that's been upstairs for probably a long time'* (Josie).

Approaches to intervention addressing the activity and participation components of the ICF, most often described by speech pathologists as 'functional approaches', were recognised by these participants as being of value and importance to people with aphasia. Rachael, an experienced clinician, described it as being important to *'try and encourage those people with*

aphasia to be as independent as possible and to be as, um, empowered I suppose as possible and not reliant on a, a relationship, um, that can't necessarily, um, extend, you know, out into the community and you know' (Rachael). Another experienced clinician, Tess, also favoured a functional approach which demonstrated *'what [people with aphasia] can do and not just seeing what they can't do'* (Tess). Some of the implications of people with aphasia not being included in communicative interactions in the acute hospital setting described by the participants included low mood, increased risk of adverse events, an inability to express their needs, and a reduction in participation in healthcare decision making. One speech pathologist described communication groups being run in the acute hospital setting to meet the needs of people with aphasia in a functional way. Others described including people with aphasia in conversation, although did not explicitly characterise this as an intervention. Primarily, the functional interventions that were described as being used in the acute hospital setting were limited to the use of personally relevant vocabulary.

'We might work on naming people in the photos...but not much work on taking them into an environmental setting or conversing with other people...not really much on training them with a conversational partner' (Amy)

It was also acknowledged by the participants that the goals of speech pathology practice may differ between the acute and sub-acute settings, with acute focussing on health from a medical perspective and sub-acute adopting a biopsychosocial perspective. These differences in perspectives, which underpin clinical practice, may go some way to explaining the reported practice in the acute care setting.

'Very blurred line': Educational and affective counselling by speech pathologists for people with aphasia and their families in the acute hospital setting

Speech pathologists who participated in this study discussed their roles in the provision of both educational and affective counselling to people with aphasia and their families in the immediate aftermath of stroke. All saw educational counselling as a central role of the profession; however, divergence in opinion existed regarding the role of the speech pathologist in the provision of affective counselling. Of interest, many reported a lack of distinction between the two counselling domains, suggesting that the boundaries between educational and affective counselling were not clearly delineated in the management of aphasia.

'I think the process of educational counselling often has a very blurry line into some emotional support. Um, because it, it just brings up all the things that they can't do, or all the things that they're having a little bit of trouble with that they used to be able to do very well, and so you then...yeah it's, it's a very blurred line I think between education and yeah, emotional counselling' (Ada)

Provision of information

Information provision was described by all participating speech pathologists as being carried out as part of their standard management pathway for people with aphasia. Despite this, no consistent process was identified. Information provision took two primary forms: provision of written information, and provision of verbal information. Written information was generally reported as taking the form of standardised, in house produced documents, handouts produced by the National Stroke Foundation, or – on occasion – guides published by the Australian Aphasia Association. The content of verbally provided information was not explicitly discussed by participants. What was evident, however, was that the majority of information regarding stroke and aphasia was provided to the families of people with aphasia rather than the people with aphasia themselves in the acute hospital setting. This is of

concern as communication professionals, through their behaviour, may be perceived as endorsing a model of care in which people with aphasia are unable to understand, to be included, or to participate in their own healthcare.

'Generally I find with somebody who is clearly going to be aphasic long term, the initial time is spent very much with supporting the family - um, educating the family, giving them lots of information, reassuring them about communication and the broader kind of, um, aspects of communication and describing what I think might be happening with their, their loved one. Um, so a lot of that acute time is spent with family rather than the patient'

Josie extended this thought, reporting that she *'think[s] it's funny what things we as a team keep from – not just as speech pathologists – not keep from patients but we don't always discuss everything that we know is probably going to happen'*.

The content of education provided to the families of people with aphasia was reported to be *'very dependent as well on the family's acceptance and the family's ability to take that on board'* (Stella). Additional characteristics that promoted the provision of education to the families of people with aphasia are described by Leah, who suggested that *'a family who's, who's concerned and present and interested, I will be putting more of a focus on educating them'*. Leah went on to characterise this as a manifestation of her family-centred practice, suggesting that *'every patient's different, and every family's different. And I think that tends to drive, in a way, the way that you work'*.

Despite their focus in clinical practice being on the provision of education to the families of people with aphasia, some participants in this study also acknowledged an awareness of

people with aphasia reporting limited access to education in the acute hospital setting.

'That counselling role can be quite tricky': Affective counselling

Participants acknowledged the emotional experience that people with aphasia and their families experience in the immediate post-stroke period, with the associated feelings of loss and grief. Ada felt that part of the reason speech pathologists may be asked to take the role of affective counselling is because *'we're the ones that understand that communication better out of all of the team members, and so the families tend to look to you and unload a little bit on you'*. However, in contrast to the congruence of opinion on the provision of informational counselling, substantial inconsistency was noted between participants when they described their involvement in the provision of affective counselling. Three distinct groups of speech pathologist participants emerged: (1) those who perceived counselling to be very much a part of their role; (2) those who put boundaries around the extent to which they would engage in counselling; and, (3) those who did not participate in the provision of counselling.

Leah suggested that *'[counselling people with aphasia is] our role more than anyone's. So, I can't shirk that'*. Agreeing with this statement, Rachael identified the significant role she played in counselling the families of people with aphasia, but also finished her statement with a concession that this may not be true for all speech pathologists.

'Certainly a lot of my role is a counselling role, um, especially I think...with families in that traumatic kind of – devastating acute setting, our role is, it definitely crosses over into pure counselling, um, without question - or certainly my role does'

(Rachael)

In contrast, a large group of participants felt that *'it's a very important part of our role to counsel about aphasia'* (Stella; authors' emphasis). They were eager to point out, however, that there were boundaries around their counselling service provision, and identified that *'there's definitely been times where I have to put my hand up and say, "You know what, I don't think I'm the right person for you to talk to"'* (Ada).

Finally, there were those who felt that counselling was definitely not the role of the speech pathologist, and created clear role distinction between themselves and other members of the multidisciplinary team more suited to the role (i.e., clinical psychologists, social workers). They suggested that, *'when [people with aphasia] start talking about that emotional loss, not just about communication...things are no longer in my expertise to talk about'* (Karen). Amy discussed feeling that *'it's hard because we're not quite trained in counselling'*. She went on to describe her lack of confidence and perceived skill in the provision of counselling:

'I think the informational type of counselling, I have the knowledge to be able to answer most of the questions, and so that's a lot easier than if it's to do with their emotions. Being able to, I guess, be supportive of them and knowing what to say is more difficult' (Amy)

The provision of affective counselling by participants in this study to people with aphasia and their families in the acute hospital setting was noted to relate not with their level of clinical experience, as may be anticipated, but rather with their perception of their role and their confidence in undertaking this task. For example, while the moderately experienced Karen and Stella did not see affective counselling as part of their role, the less experienced Celeste was more willing to take on the role.

‘We’re their voice when they don’t have one’: The advocacy role of speech pathologists in acute aphasia management

Advocating for people with aphasia was described by these participants as one of the roles they placed great emphasis on in the acute hospital setting, with some characterising advocacy as *‘my number one [thing I can do for people with aphasia]’* (Tess). The significance of this role was considered to be greater in the context of language impairment of people with aphasia, and their perceived inability to act as advocates for themselves as a result. In the words of Viv, *‘I think we do take on [the role of advocate], um, and because we can be their voice often, we’re their voice when they don’t have one’* (Viv). The advocacy role taken on by these speech pathologists took two main roles: (1) advocacy for greater awareness of aphasia within the acute hospital setting; and (2) advocacy for access to intervention for people with aphasia.

Advocacy for greater awareness of aphasia within the acute hospital setting

Raising the profile of aphasia, and other communication-related impairments, was considered by the participants in this study to be important as a means of advocating for people with aphasia. The inevitable comparison with the awareness of and focus on dysphagia management was drawn by many. One relatively inexperienced clinician commented that:

‘I suppose the sad thing is, is that everybody really focuses on, “Can they eat?” and – which is very important – but um...you know, the more I’m working in stroke the more I’m, I’m starting to realise that we, I just need to advocate more for communication impairments’ (Josie)

The perceived response to this is that *'aphasia gets left behind a little bit on the ward'* (Tess). However, while this was reported to be important by these speech pathologists, few discussed explicit strategies that they used to raise the profile of aphasia.

It was suggested by the participants that awareness of aphasia was greater in acute stroke units, *'where everybody, um, knows about communication impairments and knows they exist'* (Josie), than on general acute wards. Despite this increased awareness, Josie reported that staff in acute stroke units *'will often say the patient is confused when they're actually aphasic, and I suppose, um, advocating for a patient is, can be a bit tricky, especially when, when um, you know it's a, it's a pure aphasia and they're not confused. Um, and just constantly reminding people about that'* (Josie).

Advocacy for access to intervention for people with aphasia

The primary role of speech pathologists in advocating for access to intervention for people with aphasia was to promote the necessity of their access to rehabilitation service post-discharge. However, one participant working in the private healthcare sector additionally described the need to advocate for her patients in order to access an increased length of stay for people with aphasia. *'I mean, um, if the doctors want to push someone to be discharged because they're able to walk, they're able to eat and drink, but they're not able to communicate, um, I definitely do say that I want more time'* (Karen). An increased length of stay was considered essential in this setting, as private patients may not have access to intensive rehabilitation services in the community.

A greater proportion of participants, however, spoke about their role in fighting for access to rehabilitation services for people with aphasia outside of their ward. Some reported arguing

to have people with aphasia transferred to rehabilitation as soon as possible *'especially because you know that they're not getting the time that they, um, really should be getting while they're here in the acute setting'* (Stella). Others suggested that their advocacy was required in order to have the need for rehabilitation acknowledged at all, *'I guess advocating for the potential for change. Let's advocate for them to be able to go to rehab and have a go. Um, it doesn't mean instant nursing home, it doesn't mean instant care'* (Tess). This advocacy role was described by some as *'a battle'* (Josie), but one considered worth fighting in order to allow people with aphasia access to *'that intensive input that they deserve and that they need to improve'* (Stella).

DISCUSSION

The most striking finding of this research is the implication that there is no standardisation in the management of people with aphasia in the acute hospital setting, with significant diversity described between participants. This is perhaps not surprising given speech pathologists documented reliance on clinical expertise as a primary source of evidence [47,48]. Duffy and his colleagues [5] account for some of this variability by discussing the need to situate a hospital within a broader healthcare journey for people with aphasia with a variety of entrance and exit points, which may have a *'major influence on the nature and extent of hospital care'* (p. 49). However, the practice inconsistencies raise some questions regarding the equity of service being provided to people with aphasia and their families. While the authors do not advocate for rigid, formulaic practice – an oft cited concern of those in opposition to evidence-based practice [15] – we do support the need for clinicians working in aphasia intervention in the acute hospital setting to be supported to approximate best-practice recommendations. True evidence-based practice (EBP) requires the integration of the

research evidence, clinical expertise, the views and values of the client, and consideration of the practice context [49-51].

The variability in the acute aphasia management pathway may in part be attributable to variable levels of confidence [52] and self-efficacy [53] in the speech pathologists interviewed. This may, in part, reflect limited exposure to people with aphasia. As discussed in the introduction, dysphagia is considered to be the primary caseload for the vast majority of clinicians working in the acute hospital setting [26]. This imbalance of services was reiterated by the participants in this study, many of whom report a high representation of people with swallowing disorders on their caseload. Variation in levels of confidence and self-efficacy are strikingly overt in the participants' discussion of the provision of affective counselling, where discussion of their lack of confidence was explicit, consistent with the findings of another recent Australian study [54]. Insecurity regarding their role in communication management may be inferred by the emphasis these clinicians place on advocating for rather than providing direct therapeutic intervention to people with aphasia. The focus of energy on advocating for access to rehabilitation rather than *providing* rehabilitation may be considered conciliatory. The extent to which variability in other areas of practice may also be attributable to this a lack of confidence is worthy of further consideration, and may account for some of the unease expressed by the participants.

The speech pathologists who participated in this study reported a clear awareness of the current best-practice recommendations for the management of aphasia. Findings suggest an inherent awareness of the underlying neuroplasticity principles that apply in the acute phases of stroke recovery. In addition, acute speech pathologists are acting as advocates for the

profession and the value of intervention for people with aphasia. However, they also demonstrated a perception of little capacity to enact management consistent with these evidence-based recommendations, and articulated recognition of an evidence-practice gap. The dissonance arising from this evidence-practice gap is clearly articulated in this research, and is reinforced by similar findings in the literature [26,55].

Also evident in this study was a lack of consistent terminology across the country in relation to the management of aphasia. This was most notable in the interchangeable use of the terms 'screening' and 'assessment'. In these times of healthcare rationalisation, clarity of terminology in this area may facilitate clearer role delineation, and the potential for acceptance of alternative service delivery models. For example, communication screening may be undertaken by a trained nurse or allied health assistant, freeing up speech pathologists for formalised assessment and/or therapeutic intervention.

Speech pathologists working in the acute hospital setting work within the medical model imposed by the setting. Consistent with the medical model, the terminology used across the interview suggested a focus on the communication impairment being experienced by the person with aphasia. This is evident in the title of some of the main categories, including '*we need to know what's wrong with you so we can fix you*' (authors' emphasis), and '*we're their voice when they don't have one*' (authors' emphasis). While this perspective was not shared by all participants, the concern in relation to this narrative is that the focus on impairment and diagnosis has the potential to *disable* rather than *enable* people with aphasia. An alternative narrative could, for example, adopt a therapeutic assessment approach [56] in order to identify the strengths of people with aphasia, and supporting people with aphasia to actively participate in their own healthcare by interviewing them to understand their communication

needs in this setting [57] and through the creation of a supportive communicative environment in the acute hospital.

The findings of this research support survey data exploring aphasia rehabilitation practices within Australia [26], fleshing out the data by providing in-depth, personal accounts of current practice within the specific context of the acute hospital setting. Additionally, since the completion of data collection in this research project, the Australian Aphasia Rehabilitation Pathway (AARP) [21] was released. The AARP provides a series of best practice statements, supporting references, and useful resources, and aims to enhance clinicians' access to research evidence as a means of improving the patient experience for people with aphasia and their close others across the continuum of care. Of interest, many of the Core Areas identified in the AARP correlate with the categories emerging from the participants' discussion of their current management pathways (see table 2).

Table 2. A comparison of Core Areas from the Australian Aphasia Rehabilitation Pathway [21] and the categories emerging from the current research

AARP Core Areas	Categories emerging from the current research
Receiving the right referrals	Referral processes
Optimising initial contact	‘What [are they] gonna think of me in a year?’: First contact with the profession
Setting goals and measuring outcomes	-
Assessing	‘We need to know what's wrong with you so we can help you’: Focus on screening and assessment of aphasia in the acute hospital setting
Providing intervention	‘I do the best I can’: Approaches to intervention
Enhancing the communicative environment	-
Enhancing personal factors	-
Planning for transitions	‘We’re their voice when they don’t have one’: The advocacy role of speech-language pathologists in acute aphasia management

Comparison also reveals a number of ‘gaps’ present in the speech pathologists’ descriptions of their practice. It must, however, be noted that the AARP represents the entire rehabilitation process, rather than the acute hospital setting particularly, and as such some divergence is to be anticipated. Some gaps, however, are worth commenting on. Goal setting, for example, was discussed in a limited capacity by a small number of participants only within the category of *‘I do the best I can’: Approaches to aphasia intervention*, however did not emerge as an independent category. Explicit description of a process of collaborative goal

setting was not provided. This could, in part, be accounted for by the passive role sometimes assigned to people with aphasia in the acute hospital setting. Alternatively, consistent with the findings of Laver et al. [58] that the acute post-stroke period is more likely to be used as a ‘motivational’ phase for goal setting [59], in which patients build knowledge and develop understanding to facilitate goal creation later in their rehabilitation journey. Perhaps of greater concern is the limited discussion regarding enhancing the communicative environment. Communication access has been identified as being an issue in the acute hospital setting [60]. The potential influence that poor communicative access may have on people with aphasia’s satisfaction with their healthcare experience [2], risk of inappropriate or inadequate service provision [3], and likelihood of occurrence of adverse events [61] suggests that this should be a priority in this setting. In addition to this, enhancing personal factors did not emerge as a category within the interviews. While some individual speech pathologists discussed the need to accommodate people from culturally and linguistically diverse backgrounds, as a group the participants did not place emphasis on this area of practice. This is surprising within a culture that purports to be focused on patient-centred care.

Strengths and limitations

The strength within this study is derived from its rigorous qualitative design, with strategies to strengthen rigour implemented in the design, data collection, and data analysis phases. In addition, the context-specific nature of the research – focused on participants from the acute hospital setting alone – limit the breadth but maximise the depth of data collected.

One potential limitation of this research is the possibility that clinicians with an interest in aphasia management were more likely to self-select as participants. While this possibility is

present, the participants' reported experiences with aphasia management suggest variability in their level of interest in this practice area, as represented by statements such as, "*I acknowledge all biases; dysphagia – I love working in the area*" (Monica). An additional potential limitation of this research is that the findings may represent the aspirational rather than actual aphasia management practice of the participants. While this poses some challenges, it should be noted that the aim of this research was to represent the *participants' understanding* of their current practice. The meeting of this aim was supported by the selection of an interpretive phenomenological research strategy. It is also possible that, unlike survey methodology, the relational element created by the interview process – particularly given the perception of 'sameness' achieved as a result of the research and participants' common professional background – facilitated a more open reflection of practice. Future research could supplement the interviews with observational data and/or ethnographic methods.

CONCLUSIONS

The findings suggest that there is significant diversity in the pathways of care for people with aphasia and their families in the acute hospital setting. Additional support mechanisms are required in order to support speech pathologists to minimise the evidence-practice gap, with the additional aim of reducing their sense of professional dissonance.

The understanding of the current pathway for aphasia management that this research provides allows us to better understand current practice, and acts as a benchmark for comparison in the future. This, in combination with recently published knowledge regarding speech pathologists' perceptions of the factors that influence their practice [52] and their relationship with EBP in this context [53], creates a foundation of understanding from which speech

pathology has the capacity to shape and modify the current pathway, allowing for greater integration of evidence-based practice guideline recommendations. Future research exploring the knowledge translation strategies which could promote a reduction in the evidence-practice gap in this area is required. A demonstrable increase in evidence utilisation within aphasia management in the acute hospital setting is paramount as evidence-based practice becomes progressively more important for effective healthcare delivery.

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