College of Audiologists and
Speech-Language Pathologists of Ontario

Ordre des Audiologistes et
des Orthophonistes de l'Ontario

PRACTICE STANDARDS AND GUIDELINES FOR THE ASSESSMENT OF CHILDREN BY SPEECH-LANGUAGE PATHOLOGISTS

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EXECUTIVE SUMMARY

1. It is within the scope of practice of speech-language pathologists to assess speech and language disorders including those involving written language, social language, social interaction, cognitive communication and dysphagia.
2. Speech-language pathologists function as a resource for individuals with these disorders and their families.
3. Children may require speech-language pathology screening/assessment for communication and/or swallowing disorders, based on their communication, educational, vocational, social, health and emotional needs.
4. Speech-language pathologists must have the required resources to assess children.
5. The families/guardians of the child must be provided with information and given the opportunity to make informed choices.
6. Collaboration with other individuals involved with the child should occur when possible.
7. Speech-language pathologists must adhere to standard practices for infection control.
8. Speech-language pathologists must have the knowledge and competencies to perform assessment and screening procedures.
9. The evaluation procedure may involve screening and/or assessment.
10. In the course of assessing a child, the speech-language pathologist must:
11. Obtain informed consent to the screening/assessment procedure.
12. Assess the child's needs.
13. Make a risk management determination.
14. Follow the specified procedures.
15. Initiate the involvement of others when appropriate.
16. Discharge the child when the components of service delivery have been delivered.
17. All the required components must be documented.

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A) PREAMBLE

Practice Standards and Guidelines (PSGs) are necessary to ensure quality services to the children of Ontario who require speech-language pathology screening and assessment services. The screening and assessment components of speech-language pathology services to children are important to the provision of quality services.

It is the intent of these standards and guidelines to provide speech-language pathologists in Ontario with an overview of the screening and assessment processes and to provide some of the knowledge necessary to make responsible decisions regarding these services. This document is meant to be used as a decision-making framework and is not intended to be a tutorial or to provide speech-language pathologists with all the information required to provide screening and assessment to children. Speech-language pathologists are ethically responsible to ensure competence in performing screening and assessment and to ensure that any risk of harm is limited during the performance of these services. It is essential that speech-language pathologists have the necessary expertise, resources and equipment to perform the screening and assessment where the risk of harm of the screening and assessment may be amplified.

This Practice Standards and Guidelines (PSG) document incorporates both “must” and “should” statements. In PSGs, “must” statements establish *standards* that members must always follow. In some cases, “must” statements have been established in legislation and/or CASLPO documents. In other cases, the “must” statements describe standards that are established for the first time in these PSGs.

“Should” statements incorporated in PSGs describe best practice *guidelines*. To the greatest extent possible, members should follow these best practice guidelines. Speech-language pathologists must exercise professional judgment, taking into account the environment(s) and the individual child’s needs when considering deviating from these guidelines. Speech-language pathologists must be prepared to fully explain any departure from the guidelines.

B) DEFINITION OF SERVICE

A communication disorder is, "an impairment in the ability to receive, send, process and comprehend concepts or verbal, non-verbal and graphic symbol systems. A communication disorder may be evident in the processes of hearing, language and/or speech. A communication disorder may range in severity from mild to profound. It may be developmental or acquired. Individuals may demonstrate one or any combination of communication disorders. A communication disorder may result in a primary disability or it may be secondary to other disabilities."[1]

Skills in effective communication are necessary to function successfully in society. Communication difficulties can have a significant effect on self-esteem, education, involvement in the community and participation in society.

A median prevalence of 5.95% for children in the general population with primary speech or language delays has been found for children up to the age of 16 years.[2] More recent prevalence and incidence data[3] from a summary of available research and studies indicate that:

- Between the ages of two and four years, 4-5% of children present with stuttering. Approximately 20-25% of these children will continue to stutter.
- In school-aged children, the reported occurrence of hoarseness ranges from 6-23%.
- Prevalence estimates for language difficulty vary from 1 to 19% in children aged 3 to 5 years.
- The overall prevalence of specific language impairment (SLI) from the age of 3 years to the early school years is estimated to be between 2% and 8%.
- The median prevalence estimate for phonological disorders is in the range of 8-9%. For 80% of these children, intervention is required to remediate the disorder.
- Between 28% and 60% of children with a speech and language deficit have a sibling and/or parent who is also affected.

The philosophy of PSGs is intended to be consistent with the World Health Organization's (WHO) International Classification of Functioning (ICF), Disability and Health[4] to support the use of unified terminology across health-related disciplines. [5]

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[1] American Speech-Language Hearing Association (2000) Guidelines for the Roles and Responsibilities of the School-Based Speech-Language Pathologist. Rockville, MD: Author, pp. 15-16.

[2] Law, J., Boyle, J., Harris, F., Harkness, J. and Nye, C. (1998) Screening for Speech and Language Delay: A systematic review of the literature. *Health Technology Assessment,* 2(9).

[3] American Speech-Language Hearing Association (2004) Communication Facts: Incidence and Prevalence of Communication Disorders and Hearing Loss in Children. Rockville, MD: Author.

[4] World Health Organization. (2001). The International Classification of Functioning, Disability, and Health. Geneva, Switzerland: Author.

[5] Threats TT: The world health organization's revised classification: What does it mean for speech-language pathology? Journal of Medical Speech-Language Pathology. Vol. 8(3)(pp xiii-xviii), 2000.

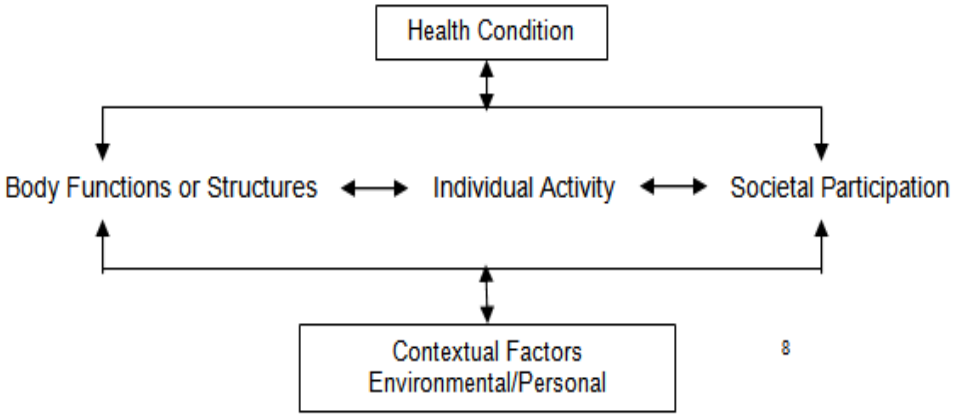
[6] [7] Discussion of communication and swallowing difficulties is framed using WHO terminology as illustrated below.

The overall objective of speech-language pathology services is to optimize individuals' ability to communicate in natural environments, and thus improve their quality of life. This objective is best achieved through the provision of services that are integrated into meaningful life contexts. The WHO's established health classification system, the ICF, offers service providers an internationally-recognized conceptual framework and common language for discussing and describing human functioning and disability. This framework can be used to describe the role of speech-language pathologists in enhancing quality of life by optimizing human communication behaviour and swallowing, regardless of setting.

Dimension	**Definition**	**Examples**
Impairment	Problems in body structures and/or body functions such as significant deviation or loss	Examples of specific impairments that may affect communication: impaired attention, impulsivity, inefficient processing of information (rate, amount and complexity), difficulty processing abstract information, articulation delays, fluency disorders, cleft palate, swallowing disorders, reading and writing disorders, etc.
Activity/ Participation	Aspects of functioning from an individual or societal perspective	Examples of limitations and restrictions: difficulty in conversations, limitations in expressing ideas, opinions, choices, wants and needs, social isolation, dependence on others for functional communication, academic difficulties
Contextual Environmental Factors	Factors that impact disability ranging from the individual's immediate environment to the general environment	Examples of difficulties imposed by the environment: lack of family and friendship support, reduced social acceptance, financial constraints, inflexible academic environment
Contextual Personal Factors	Individual factors that influence performance in the environment	Examples of relevant individual factors: race, gender, age, lifestyle, habits, upbringing, coping styles, social background, education, past experiences, character style, behaviour

[6] Threats TT and Worrall L: Classifying communication disability using the ICF. Advances in Speech-Language Pathology 2004 Mar; 6(1): 53-62.

[7] Reed GM, et al.: Operationalizing the international classification of functioning, disability and health in clinical settings. Rehabilitation Psychology 2005 May; 50(2): 122-31.



Services offered to children by speech-language pathologists encompass all components and factors identified in the WHO framework. That is, speech-language pathologists work to improve quality of life by reducing impairments to communication and oral-motor functions and structures, lessening limitation to activity and participation and/or modifying the environmental barriers of the individuals they serve. They serve individuals with known impairments, delays or disorders (e.g. cleft palate, hearing loss, syndromes) as well as those with activity limitations or participation restrictions (e.g. children needing classroom support services or special educational placement, children who are unable to communicate effectively), including when such limitations or restrictions occur in the absence of known aetiologies or impairments (e.g. children with differences in dialect, children with no known aetiology for their communication delay). The role of speech-language pathologists includes prevention of communication and swallowing disorders, as well as identification, habilitation, rehabilitation, and enhancement of these functions.

C) SCOPE OF PRACTICE

The *Audiology and Speech-language Pathology Act,* 1991, states: "The practice of speech-language pathology is the assessment of speech and language functions and the treatment and prevention of speech and language dysfunctions or disorders to develop, maintain, rehabilitate or augment oral motor or communicative functions." The disorders discussed in this document are generally understood to be speech and language disorders, and all also fall under the rubric of "oral motor or communicative" disorders. Although written language, social language and social interaction are not specifically stated within the scope of practice, they are implied by the terms "language functions" and "communicative functions." While dysphagia is not expressly indicated within the scope of practice, it is, however, implied by "oral motor functions." As a result, CASLPO maintains that the assessment and treatment of dysphagia is within the speech-language pathology scope of practice. Cognitive-communication disorders are also a well-defined and internationally accepted area of practice within the field of speech-language pathology.

As stated in CASLPO's Code of Ethics, members "will practice within the limits of their competence as determined by their education, training, and professional experience." Each individual speech-language pathologist's scope of practice with regard to these PSGs may vary based on this statement.

As well as providing screening/assessment, speech-language pathologists may act as a resource for children, families, other significant individuals in the child's environment (e.g. teachers, caregivers) and the community at large. This role may involve educating the public regarding communication and swallowing disorders, promoting awareness of processes to access speech-language pathology intervention, and gathering and presenting data to advocate for effective services.

D) TARGET PATIENT/CLIENT POPULATION

These Practice Standards and Guidelines focus on children who require speech-language pathology screening/assessment for communication and/or swallowing disorders, based on their communication, educational, vocational, social, health and emotional needs. The term “child” is used throughout the document with an understanding that within educational settings children may be referred to as students, and in health settings children may be referred to as clients or patients. For the purpose of these PSGs, “child” has been defined as a person 18 years of age and under. It is recognized that, in some situations, these PSGs may apply to individuals above the age of 18, for example, in the education system where some individuals attend secondary school until the age of 21.

E) RESOURCE REQUIREMENTS

Guide E.1	SLPs should ensure that the physical environment is appropriate for the procedure.

Speech-language pathologists should ensure that the physical environments are appropriate for the screening/assessment procedures involved. It is acknowledged that the most effective screening/assessment will take place in the child's natural environment. It is however also acknowledged that environments for screening/assessment will be dictated by workplace limitations, space constraints, time limitations, organizational policies and a number of other factors. To the greatest extent possible, the environment where the screening/assessment is conducted should be appropriate with regard to the procedures.

 Standard E.1	SLPs must ensure that all equipment is calibrated and in proper working order.

For some interventions, specialized equipment will be necessary. Equipment should be maintained according to manufacturers' specifications and recommendations. Speech-language pathologists must ensure that all equipment used is calibrated and in proper working order, as required in the Code of Ethics.

 Standard E.2	SLPs must ensure that records are securely stored.

Records must be stored securely in accordance with CASLPO's current Proposed Regulation for Records and any other relevant legislation, such as the *Personal Health Information Protection Act*, 2004.

F) COLLABORATION REQUIREMENTS

Guide F.1	SLPs should ensure that the families are fully informed and provided with timely information.

Collaboration is critical to the screening/assessment process. With collaboration, communication partners who play a pivotal role in the child's environment can determine which interactive skills are important and can describe the child's success in using these skills in natural environments. For example, parents, teachers and child care/school staff may provide information on the child's ability to communicate at home, in school and child care settings.

Families/guardians are integral to the assessment process unless the mentally capable child refuses their involvement. Service provision should allow for parent/guardian choice that is fully informed and based on unbiased information. The family's and child's perspectives should be given primary consideration. The family should be provided with information that is timely, comprehensible, relevant, complete, unbiased and evidence-based.

Standard F.1	SLPs must be sensitive to the family's cultural background.

Speech-language pathologists must be sensitive to the family's cultural background as discussed in CASLPO's Position Statement "Service Delivery to Culturally and Linguistically Diverse Populations" (2000).

Standard F.2	SLPs must have consent when communicating with others.

Collaboration with other individuals involved with the child (for example, other caregivers, teachers, psychologists, rehabilitation professionals, audiologists, other speech-language pathologists) should occur when possible. Such an approach requires familiarity with the roles played by caregivers and other professionals involved with the child and/or family. The degree to which collaboration can occur may be dependent on the setting.

The collaborative model is critical to the screening/assessment process. With collaboration, communication partners who are pivotal in the child's environment can determine which interactive skills are important and can describe the child's success in using these skills in natural environments. For example, teachers and child care/school staff may provide information on the child's ability to communicate in those settings.

Speech-language pathologists must have appropriate consent when communicating with others involved with the child or family as indicated in CASLPO's Professional Misconduct Regulation and the *Personal Health Information Protection Act* (PHIPA), 2004.

Standard F.3

SLPs must communicate with other SLP(s) when providing concurrent services.

In contexts where the child is receiving services from another speech-language pathologist or from an audiologist, two CASLPO members may be involved concurrently, when the intervention is determined to be in the best interests of the child and is provided according to the CASLPO Position Statement "Concurrent Intervention Provided by CASLPO Members" (2001).

G) HEALTH AND SAFETY PRECAUTIONS

Standard G.1

SLPs must employ standard practices for infection control, as well as additional precautions where specified by the practice setting or by the child's service providers.

All procedures must ensure the safety of the child and speech-language pathologist and adhere to standard practices for infection control, as indicated in the CASLPO document "Infection Control for Regulated Professionals" (2006), as well as additional precautions where specified by the practice setting or by the child's service providers.

H) COMPETENCIES

 Standard H.1	SLPs must practice within the limits of their competence for screening/assessment.

When providing services, speech-language pathologists must practice within the limits of their competence "as determined by their education, training and professional experience" as indicated in the Code of Ethics. Further details are available in the scope of practice section of these PSGs.

 Standard H.2	SLPs must ensure that they have the required competencies.

Speech-language pathologists must ensure they have the required competencies for the services provided.

Competencies required for screening/assessment of children with communication and/or swallowing disorders include:

I. SCREENING

1.1 Demonstrates knowledge of developmental milestones related to communication and swallowing.

1.2 Demonstrates knowledge and skills required to select appropriate screening measures, according to all relevant factors such as the child's chronological and developmental age, cultural/ethnic, social and linguistic background and the requirements of the specific screening situation, to administer the screening measures, to interpret results to identify children most likely to have communication and/or swallowing disorders, and to recommend further assessment(s).

1.3 Demonstrates knowledge of roles and responsibilities of other professionals who are involved in early identification of communication and swallowing disorders.

1.4 Demonstrates knowledge and skills required to supervise supportive

personnel.

a) Ability to train and supervise supportive personnel involved in screening.
b) Knowledge of when it is appropriate to utilize supportive personnel.

II. ASSESSMENT

All the competencies required for screening of children (1.1 to 1.4) are also required for assessment. For assessment, the following competencies are also required:

2.1 Demonstrates knowledge of neuroanatomy and anatomy of speech and swallowing mechanism.

2.2 Demonstrates knowledge of neuroanatomy of language mechanism.

2.3 Demonstrates knowledge of theories of speech, language and swallowing development and potential disorders.

2.4 Demonstrates knowledge of conditions that would impact on the development of speech, language and swallowing disorders.

2.5 Demonstrates knowledge of developmental milestones related to speech, language and swallowing.

2.6 Demonstrates knowledge of the roles and responsibilities of other professionals and of how and when to recommend
the involvement of other professionals, to enhance the team approach in providing a comprehensive assessment.

2.7 Demonstrates appropriate selection, administration and interpretation of assessment procedures in order to identify the presence, nature and functional implications of communication and swallowing disorders in children assessed, including:

a) Skills to obtain sufficient background information pertinent to the assessment of the child.
b) When possible and with appropriate consent, skills to obtain, analyze and integrate the results of interventions from other individuals involved with the child.
c) Knowledge of current material and approaches that are appropriate to the child's chronological and developmental age, cultural/ethnic, social and linguistic background and the requirements of the specific assessment situation.
d) Skills in selecting and administering appropriate standardized assessment procedures including knowledge of aspects such as test protocols, validity and reliability.

e) Skills in selecting and administering appropriate nonstandardized assessment procedures including knowledge of the limitations and appropriate uses of these types of procedures.
f) Skills in interpreting the results of standardized and nonstandardized assessment procedures.
g) Skills to determine the significance and implications of cultural and linguistic differences.
h) Skills to determine the significance and implications of atypical findings of assessment including the functional impact.
i) Knowledge of appropriate follow-up options based on interpretation of assessment results.
j) Skills to formulate recommendations and set appropriate goals for intervention to support communication and/or swallowing functions. Organizational policies and procedures may impact on the interventions that can be provided. Where this occurs, it must be documented in the child's patient/client record.
k) Knowledge of referral procedures when recommending further assessment by other professionals including other speech-language pathologists.
l) Skills to communicate results of assessment to parents/guardians, other caregivers and professionals, for example, the implication of the results on activity/participation and context (using WHO ICF terminology).
m) Skills to discuss follow-up options with parents/guardians.
n) Skills to monitor and measure outcomes of assessment services in order to ensure the quality of assessments provided and to improve the quality of those assessment services.

3. Demonstrates knowledge and skills required to supervise supportive personnel
a) Ability to train and supervise supportive personnel involved in assessment.
b) Knowledge of when it is appropriate to utilize supportive personnel.

4. Demonstrates continued acquisition of knowledge and skills necessary to provide high quality assessment of communication and/or swallowing disorders.
a) Knowledge of current literature and research in the area of assessment of communication and swallowing disorders in children.
b) Knowledge of current assessment approaches.
c) Ability to apply the knowledge described above to service provision.

J) COMPONENTS OF SERVICE DELIVERY

1. CONSENT

Standard J.1	SLPs must obtain valid and informed consent for all screenings and assessments, as indicated in the CASLPO position statement "Consent to Provide Screening and Assessment Services". SLPs must also obtain knowledgeable consent for the use and collection of information obtained during screening/assessment. SLPs must document every verbal and written consent received regarding screening/assessment.

Speech-language pathologists must obtain valid and informed consent from the child or substitute decision-maker, as indicated in the CASLPO position statement "Consent to Provide Screening and Assessment Services", for all screenings and assessments. To obtain informed consent, as defined in Health Care Consent Act, 1996, it is necessary to provide the following information: the nature of the service, the expected benefits, any probable or serious risks and side effects, alternative courses of action, and the likely consequences of not having the screening/assessment. Speech-language pathologists are reminded that the crucial element in obtaining consent is the discussion of the information listed above and not the act of signing a consent form. Informed consent to perform a screening/assessment can be provided in written or verbal form.

The *Personal Health Information and Protection Act* (PHIPA), 2004, requires that members must also obtain knowledgeable consent to the collection, use and disclosure of any information obtained during screening/assessment. This consent can also be provided in written or verbal format.

Speech-language pathologists must document in the child's record every verbal and written consent received regarding screening/assessment.

Organizations may have various procedures for obtaining consent for the provision of screening/assessment and for the collection and use of information. These may be utilized if they comply with the Health Care Consent Act, 1996, the *Personal Health Information Protection Act*, 2004, and CASLPO requirements.

It is recognized that, depending on the child and the situation, children may be involved to various degrees in the screening/assessment process. The *Health Care Consent Act,* 1996, indicates that there is no fixed age at which a child becomes mentally capable of providing consent. As a result, children who are judged mentally capable to provide informed consent may choose to include or exclude their parents/caregivers from the screening/assessment process. Children are

considered capable if they are able to understand the information provided and appreciate the consequences of the decision.

Consent can be withdrawn at any time by the child (if mentally capable) or the parent/substitute decision maker.

Speech-language pathologists are reminded that, where in these PSGs the involvement of families and parents is discussed, this may also include the participation of the child.

2. RISK MANAGEMENT DETERMINATION

Standard J.2	SLPs must conduct a risk management determination.

SLPs must take steps to minimize any risks associated with the screening/assessment. These risks include but may not be limited to:

- Any risks of physical or emotional harm to the child resulting from the screening/assessment.
- The risk of incorrectly conducting the screening/assessment and identifying a delay or disorder that is not present, resulting in for example, unnecessary concern for the child and/or family.
- The risk of incorrectly conducting the screening/assessment and not identifying a delay or disorder that is present, resulting in social/educational/vocational consequences associated with untreated communication and/or swallowing delays or disorders.
- Risks associated with not performing the screening/assessment, for example a child may not receive a required screening/assessment, resulting in an untreated delay or disorder.

3. PROCEDURES

A. CONTINUUM OF CARE

The following are the fundamental components of screening/assessment of all communication and/or swallowing disorders. CASLPO Preferred Practice Guidelines and Practice Standards and Guidelines for specific communication and/or swallowing disorders may be available and must be used in conjunction with these PSGs.

B. SCREENING

Guide J.1	SLPs should use the child's chosen communication mode and linguistic system.

Purpose of Screening

1. To identify children who may have communication and/or swallowing delays/disorders. Screening is only used to determine the need for a speech-language pathology assessment. Screening results cannot be used for treatment planning.
2. Screening may also result in recommendations for assessments or services in areas other than speech-language pathology.

Role of Support Personnel

Support personnel, supervised by a speech-language pathologist, may perform specific pass/refer screening procedures, in accordance with CASLPO's Position Statement "Use of Support Personnel by Speech-Language Pathologists" (2007).

Procedural Elements

1. Screening includes one or more of the areas of communication and/or swallowing function, including but not limited to articulation/phonology, oral-motor function, voice, fluency, language, swallowing and hearing.

2. Screening procedures may be developed to screen identified communication and/or swallowing functions. Screening may be a component of an assessment when mandates require it.

 Standard J.3	SLPs must be aware of linguistic and cultural factors, as discussed in CASLPO's Position Statement "Service Delivery to Culturally and Linguistically Diverse Populations" (2000), when conducting a screening.

3. Screening should be conducted in the child's chosen communication mode and linguistic system and in consideration of his or her cultural background and community.

4. Speech-language pathologists should use current material and approaches that are appropriate to the child's chronological and developmental age,

cultural/ethnic, social and linguistic background and the requirements of the specific screening situation.

Guide J.2	SLPs should use current and appropriate materials and approaches when conducting a screening.

Guide J.3	SLPs should report results to parents/caregivers and, where appropriate, the child.

5. Speech-language pathologists should use current material and approaches that are appropriate to the child's chronological and developmental age, cultural/ethnic, social and linguistic background and the requirements of the specific screening situation.

Outcomes

Standard J.4	SLPs must ensure outcome as described when conducting a screening.

Outcomes must be one or more of the following:

1. Recommendation for an in-depth communication and/or swallowing assessment in general or specific areas.
2. No further services or assessment required at this time.

Screening may also result in recommendations for assessments or services in areas other than speech-language pathology.

C. ASSESSMENT

Purpose of Assessment

1. Assessment is conducted to determine a child's functional communication and/or swallowing status, resulting in one or more specific conclusion(s).
2. Assessment is prompted by a referral, a request, or a "refer" screening result.
3. Assessment may also result in recommendations for follow-up, including recommendations for assessments or services in areas other than speech-language pathology.

Role of Supportive Personnel

Supportive personnel may assist speech-language pathologists in assessment administration with appropriate supervision and in accordance with CASLPO's Position Statement "Guidelines for the Use of Supportive Personnel" (1997).

Procedural Elements

 Standard J.5	SLPs must ensure that the assessment as defined in these PSGs is sufficient to make recommendations for follow-up or to indicate that no follow-up is required, when conducting an assessment.

1. Assessment may be completed in one session or require observation/assessment over time or in different environments. Although continuing intervention may result in ongoing assessment over time, the initial assessment as defined in these PSGs must be sufficient to make recommendations for follow-up.

Guide J.4	SLPs should use the child's chosen communication mode and linguistic system.

2. Assessment should be conducted in the child's chosen communication mode and linguistic system and in consideration of his or her cultural background and community.

 Standard J.6	SLPs must be aware of linguistic and cultural factors, as discussed in CASLPO's position statement "Service Delivery to Culturally and Linguistically Diverse Populations" (2000), when conducting an assessment.

Speech-language pathologists must endeavour to provide services that are receptive and responsive to the cultural and linguistic needs of children, as discussed in CASLPO's position statement "Service Delivery to Culturally and Linguistically Diverse Populations" (2000). Speech-language pathologists must be aware that complex linguistic and socio-cultural factors affect communication and must incorporate this knowledge into their assessment of the child.

Guide	SLPs should use current and appropriate materials and approaches

J.5	when conducting an assessment.

3. Speech-language pathologists, as appropriate, should work in collaboration with the child, parents/caregivers, and other professionals and individuals.

Guide J.6	SLPs should report results to parents/caregivers and, where appropriate, the child when conducting an assessment.

4. Outcomes of assessment services should be monitored and measured in order to ensure the quality of assessments provided and to improve the quality of those assessment services.

Assessment must include:

Standard J.7	SLPs must include specified elements when conducting an assessment.

1. Assessment of the identified area(s) of communication/swallowing concerns that prompted the assessment, using the appropriate standardized and/or non-standardized procedures.

2. Observation of areas of communication function, such as articulation/phonology, oral-motor function, voice, fluency, language, swallowing and hearing. Observation may be informal or formal and may indicate the need for formal assessment at a later date.

3. Methodology based on sound professional judgment.

4. Obtaining a case history that provides sufficient background information. This will vary, depending, for example, on the age of the child, the environment/sector and the type of assessment.

5. Review of medical, educational, auditory, visual, fine/gross motor and/or cognitive (and others as appropriate) status as assessed by other professionals, as available.

6. Child and family-centred approach addressing all appropriate communication contexts.

7. Parent/caregiver counselling to address the nature of the communication or related delay/disorder and its impact, recommended follow-up plan, and possible outcomes of the procedures. Counselling may take many forms and will be dependent on the situation and environment.

Outcome

 Standard J.8	SLPs must ensure outcomes as described when conducting an assessment.

Outcomes must be one or more of the following:

1. Description of characteristics of communication, and identification of the presence or absence of age-appropriate communication and/or swallowing skills, and of strengths and weaknesses.

2. Recommendation for a follow-up plan, if required, along with the rationale for the follow-up plan.

Assessment may also result in recommendations for assessments or services in areas other than speech-language pathology.

5. INITIATING INVOLVEMENT OF OTHERS

Guide J.7	SLPs should recommend involvement of appropriate professionals as needed.

For some children, there may be other areas of concern (for example in the areas of hearing, fine/gross motor skills, behaviour, cognition, academic skills, social skills, family issues, etc.). The speech-language pathologist should recommend involvement with appropriate professionals when necessary. These professionals may include but are not limited to audiologists, other speech-language pathologists, occupational therapists, physiotherapists, physicians, classroom teachers, psychologists, social workers, teachers of the deaf/hard of hearing and special education teachers. Directing parents/guardians to community resources such as parent/consumer groups should also be considered for families to obtain additional information and support.

6. DISCHARGE CRITERIA

A child is discharged from the screening/assessment procedure when one or more of the following criteria are met:

1. The speech-language pathologist has the necessary information to determine the appropriate next steps.
2. The substitute decision-maker or child has the information that they require.
3. Consent for the screening/assessment is withdrawn.

K) DOCUMENTATION

1. DOCUMENTATION FOR SCREENING:

Standard K.1

SLPs must document the screening procedure as indicated above and also in accordance with CASLPO's current Proposed Records Regulation and must complete documentation in a timely manner.

Screening documentation in the child's record must comply with CASLPO's current Proposed Regulation for Records and must also include the following:

1. The child's name and at least one other identifier, or documentation of the child or substitute decision maker's refusal to provide the additional identifying information.

2. Screening procedure(s).

3. Screening outcome of "pass" or "refer".

4. Information about any follow-up by the speech-language pathologist

Screening documentation must be completed in a timely manner reflecting the acuity of the situation.

Screening documentation must be completed in a timely manner reflecting the acuity of the situation.

2. Documentation for Assessment:

Standard K.2

SLPs must document all specified areas of assessment as indicated above and also in accordance with CASLPO's current Proposed Records Regulation and must complete documentation in a timely manner.

Assessment documentation in the child's record must comply with CASLPO's current Proposed Regulation for Records and must also address the following areas:

1. Pertinent background information.
   This may include for example:

a. Health, family, educational, social and vocational history, where appropriate.
b. Results of related screenings, assessments, other professionals' assessment results and follow-up procedures, if available.

2. Assessment procedures
   These may include for example:
   a. Tests and measures used.
   b. Dates and locations of assessment.
   c. Description of any adverse testing environments.

3. Pertinent behavioural observations from the assessment.

4. Results from observation or assessment of areas of communication and/or swallowing such as:
   (i) Articulation/phonology/oral-motor
   (ii) Voice
   (iii) Fluency
   (iv) Language
   (v) Swallowing
   (vi) Hearing

5. Pertinent results regarding activity limitations and participation restrictions related to the impact of any identified communication and/or swallowing difficulty on daily functioning (work, school, social, community independence, family).

6. Interpretation and analysis of assessment results.
   This may include for example:
   a. Addressing the presence/absence of a delay/disorder, the type and severity of the communication delay/disorder and/or swallowing disorder and associated conditions (e.g. medical diagnoses, disability).
   b. A reasonable statement of potential outcome, although the outcome of any intervention plan is not guaranteed.

7. Recommendations:
   These may include for example:
   a. Recommendations for speech, language and/or swallowing intervention.
   b. Recommendations for consultations and/or further assessments/services by other professionals.
   c. No further services or assessment required.

Assessment documentation must be completed in a timely fashion reflecting the acuity of the situation.

L) GLOSSARY

Assessment: Use of formal and/or informal measures by an audiologist or speech-language pathologist, in accordance with the member's scope of practice, to determine a patient/client's functioning in a variety of areas of functional communication and/or swallowing or hearing, resulting in specific treatment recommendations.

Child: A person 18 years of age and under. In some situations, these PSGs may apply to individuals above the age of 18, for example in the education system, where some individuals attend secondary school until the age of 21.

Contexts: The different environments in which patients/clients, their family members and other significant individuals may be communicating. Different contexts may affect communication and/or swallowing in different ways.

Family-centred: Collaboration with the patient/client's family/caregivers in the service provision.

Intervention: Includes any member or supportive personnel involvement in the provision of member services to patients/clients, including but not limited to screening, assessment, treatment and management.

Screening: Screening is a process where a member applies certain measures that are designed to identify patients who may have a hearing, balance, communication, swallowing or similar disorder[s], for the sole purpose of determining the patient's need for a speech-language pathology assessment, an audiological assessment, or both. This does not include:

a. Inadvertently noticing possible hearing, balance, communication, swallowing or similar disorder[s], or

b. Considering information that is shared about an individual's possible hearing, balance, communication, swallowing or similar disorder[s], for the purpose of providing general educational information and/or recommending a referral for a speech-language pathology screening or assessment, an audiological screening or assessment, or both."

Interpretation and communication of the results of a screening are limited to advising the individual on whether or not there may be a need for a speech-language pathology assessment and/or an audiological assessment and must not be used for treatment planning.

Treatment: An intervention which has as its goal to enhance the communication and/or swallowing skills of the patient/client.

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