



College of Audiologists and
Speech-Language Pathologists of Ontario

Ordre des audiologistes et
des orthophonistes de l'Ontario

GUIDE TO THE CLINICAL REASONING TOOL

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GUIDE TO THE CLINICAL REASONING TOOL

1) INTRODUCTION

This guide is intended for the member being peer assessed and the peer assessor. The College's Quality Assurance Program, through the Self-Assessment Tool (SAT), requires Audiologists (AUD) and Speech Language Pathologists (SLP) to reflect on their practice, determine if they meet the professional practice standards, develop learning goals and obtain Continuous Learning Activity Credits (CLACs).

Clinical reasoning is an essential component of quality practice in every clinical role across all service delivery models. Many CASLPO members who have participated in the Peer Assessment process have commented that they would benefit from patient discussion:

"The chart review was fine, but I wanted more feedback and discussion about the charts."

"I feel that my actual clinical work was not explored."

Assessing clinical reasoning is an established process across many health care professions. Canadian faculties of medicine use **Chart Stimulated Recall** as a method of examining critical reasoning and clinical decision making to:

- identify critical thinking and reasoning skills
- stimulate reflective practice
- provide feedback
- improve documentation skills
- help demonstrate and evaluate roles and competencies
- help structure a teaching session
- identify gaps in knowledge

Dept. Family Medicine, University of Alberta (2009)

Health regulated colleges across Canada have incorporated different methods to evaluate their members' clinical reasoning in their quality assurance programs.

CASLPO is introducing the **Clinical Reasoning Tool** (CRT) as part of the peer assessment process.

The CRT is a method of evaluating clinical reasoning through a guided conversation. It consists of a set of discussion questions designed to reveal the clinical reasoning the member has applied and to promote reflective practice. Effective clinical reasoning can result in many different but equally good clinical decisions.

AUDs and SLPs participating in Peer Assessment are required to participate in the CRT evaluation process with the peer assessor.

1.A) CLINICAL REASONING: DEFINITION

Clinical reasoning describes the ongoing process by which members collect, analyse and evaluate information and come to an understanding of a patient problem or situation. Further, how members plan and implement interventions, evaluate outcomes, and reflect on and learn from the process.

1.B) ASSUMPTIONS

The College assumes that AUDs and SLPs:

- have the required knowledge, skills and judgement to practice effectively within their scope of practice
- comply with legislation, the Code of Ethics, regulations and practice standards
- follow professional principles, such as using evidenced based practice, a patient centered approach and sound clinical reasoning

One of the goals of the Quality Assurance Program is to confirm the College's assumptions, assuring the public that all AUDs and SLPs provide quality care.

2) GUIDE TO EVALUATION

2.A) WHAT WILL BE EVALUATED

The member and peer assessor will discuss two patient records focussing on the clinical reasoning process (see chart below) and the clinical decisions that were made. The CRT is a method to allow the member to "tell the patient's story". In doing so, the CRT will allow members to:

- analyse their clinical thinking
- demonstrate the reasoning behind clinical decisions
- reflect on the patient's experience
- generate ideas about clinical intervention for current and future patients

The following table outlines features of the clinical reasoning process. Peer assessors use these features to determine whether and how the member applies clinical reasoning.

Members are not required, nor expected to have documented the internal process of clinical reasoning in the patient record. However, through your conversation, these clinical reasoning features will be apparent.

TABLE 1 CLINICAL REASONING PROCESS

HAS THE MEMBER

• collected sufficient information?
• applied background/clinical information in the decision-making process?
• linked information from one phase of intervention to the next?
• incorporated the patient's context and situation into areas of intervention decision making?
• considered options and provided a reasonable rationale to eliminate other options?
• Shown a flexible approach regarding the patient, their needs or other intervention options
• provided a reasonable rationale to explain why they did what they did

2.B) WHAT WILL NOT BE EVALUATED

The CRT does NOT assess members' clinical choices. It is an evaluation of the extent to which members engaged in clinical reasoning to arrive at their decisions.

The process is not an evaluation of members' communication skills. Some members find it easy to discuss a clinical situation while others do not. Additional discussion questions have been included to help members expand on their clinical reasoning.

2.C) CLINICAL REASONING TOOL: FORMAT

2.C I) DISCUSSION AREAS

+	DISCUSSION AREAS	COMMENTS
	PATIENT OVERVIEW	
	1) Briefly, give me some background information about this patient	

The discussion areas are designed to be applicable in different environments ranging from direct patient care to consultation and with all ages.

They comprise

- Patient Overview
- Screening and Assessment

- Management
- Discharge/Follow Up
- Reflections

There are many different models of care and clinical scenarios. Not all sections of the CRT will apply to every member or patient. The peer assessor will take the member’s clinical context into consideration.

Examples:

- The member may only screen patients and make referrals. In this situation they would not discuss the management section, but would discuss discharge planning and follow up.
- The member may not have assessed the patient themselves, but may be able to discuss how the assessment directed the management plan.
- If a member is taking on a patient from another member with an established plan of care the peer assessor will focus the discussion on areas other than screening and assessment.

2.C II) ADDITIONAL DISCUSSION POINTS

<p>2) What is/was unique about this patient?</p> <ul style="list-style-type: none"> • Cultural considerations • Psychosocial issues • Behaviour • Medical history

The Tool includes ‘additional discussion points’, bullets below the key questions. The peer assessors may ask these additional discussion questions to help the member or if the member’s responses are sparse and/or do not show sufficient clinical reasoning.

The peer assessor will, if necessary, pose additional discussion questions according to the conversation and member’s context.

Example1:

Discussion Area: How did the background information you collected direct your assessment?

Response: I always do an artic assessment with artic kids (insufficient patient context and options).

Additional Discussion: Did any information lead you to use an informal (or formal) assessment approach?

Response: The boy was outgoing and happy to come with me, he also had reasonable attention, he was able to tolerate a formal articulation assessment and I got the information I needed to develop a therapy plan (reasonable rationale).

Example 2:

Discussion Area: What was unique about this patient?

Response: Nothing really, he was a typical 80 year old with a hearing loss who needed aids (insufficient patient context and collection).

Additional Discussion: Were there any cultural factors that made him unique?

Response: Well he came from a large family who got together on a regular basis. His wife said that he is isolating himself at family gatherings and not conversing or participating. She was concerned that he was missing out (patient context, collected information).

Example 3:

Discussion Area: How did you decide to continue with or move onto another section of the management plan?

Response: She's got severe swallowing problems so we haven't moved on (insufficient patient context and options).

Additional Discussion: What client-centred factors have you considered?

Response: This patient has advanced dementia and cannot tolerate a texture upgrade. There are real safety issues. However, the dietitian and I met with the family to discuss what foods she liked and disliked and we monitor her intake. The dietitian and I meet at weekly rounds to discuss the patient, and we do joint reassessments when nursing inform us there is an issue (reasonable rationale).

2.C III) CLINICAL REASONING PROCESS

Collected, Applied, Linked, Patient Context, Options, Flexible, Reasonable

For each Discussion Area (Patient Overview, Screening, Assessment etc.), the Tool identifies the expected Clinical Reasoning Processes (see Table 1)

EXAMPLES OF THE CLINICAL REASONING PROCESS

DISCUSSION AREAS	CLINICAL REASONING EXAMPLE	EVIDENCE OF CLINICAL REASONING PROCESS
What is unique about this patient?	She was from Pakistan and spoke Urdu. She appeared to understand English, but I repeated the information and wrote out my findings about her hearing using simplified language to make sure she understood.	Collected sufficient information Applied information Patient's context acknowledged Flexible Reasonable rationale
What is unique about the student?	When talking to mom she said that her son was very shy, she also said he loved dinosaurs. I used dinosaurs to engage and develop a relationship with the student before I assessed him.	Collected sufficient information Applied information Patient's context acknowledged Flexible Reasonable rationale
Did anything lead you to change your assessment plans?	No, the assessment protocol we use here at the school board gave me enough clinical information that I felt that I could devise an appropriate therapy plan to discuss with the parents.	Collected sufficient information Applied information Reasonable rationale to eliminate other options Reasonable rationale
How did the assessment results help you develop your management plans?	The assessment showed that the patient has moderate fluent aphasia at a conversation level. His wife told me that before his stroke he used to 'Skype' his daughter in B.C every Sunday. The therapy plan focussed on developing and communicating one piece of news for his daughter, asking his daughter one question per week, and evaluating communication success.	Collected sufficient information Applied information Linked information Flexible Reasonable rationale
How did you decide to change or move onto another section of the management plan?	Generally I follow the criteria that if the target behaviour is achieved 80% of the time, then I move on. This child struggled with one element of the plan, so I decided to go back to a skill they had achieved to increase confidence and motivation.	Collected sufficient information Applied information Flexible Considered other options Reasonable rationale
Did you involve others in intervention? How did you come to that decision?	At the interdisciplinary rounds at the hospital, I recommended that nursing include oral care following mealtimes, due to pocketing of food, to ensure optimum safety for the patient. The patient was pocketing a lot of food on the left side at mealtimes.	Collected sufficient information Applied information Considered other options Reasonable rationale

How did you decide whether or not your patient needed further audiology/SLP or other professional intervention?	I decided that I didn't need to see the patient until their annual check-up. Their prescribed aids were verified and validated. The patient was able to use, store and clean the aids appropriately. They were also told to contact the office if there were any problems or new concerns.	Collected sufficient information Applied information Reasonable rationale to eliminate other options Reasonable rationale
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2.C IV) COMMENTS

The peer assessor may write comments to help them with their final evaluation. The peer assessor does not have to write a summary of the actions taken by the member to show clinical reasoning. If the member's actions demonstrate adequate clinical reasoning, they might write "complete and reasonable".

DEFINITIONS

Reasonable: What a hypothetical, typical member who exercises average care, skill, and judgment would do in similar circumstances and thereby serve as a comparative standard.

Intervention: Includes screening, assessment, management, direct and indirect treatment, consultation, monitoring etc. In other words, any type of clinical interaction with the patients and others to meet the patients' clinical goals.

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

Management: Includes treatment (direct and indirect), consultation, monitoring, follow up, counselling, education and discharge planning.

3) CLINICAL REASONING EVALUATION: PROCESS

3.A. CHART SELECTION AND PREPARATION (MEMBER)

- Review the 10 patient records you have selected for the peer assessment before the site visit, so you are familiar with them.
- Two patient records will be discussed. Select one interesting or challenging patient from the 10 prepared records. Think about a patient that will stimulate a good discussion regarding clinical reasoning.

- The patient record should be a current patient or very recently discharged so you can recall your clinical decisions.
- The peer assessor will select an additional patient record, preferably current, from the set of prepared records. They will choose a patient record that is different for the member's choice (age, diagnosis, phase of intervention etc.) as available.
- The peer assessor will give you time to review both patient records before starting the Tool.
- The clinical reasoning process is not typically documented in the patient record but is revealed through discussion.

3.B. CLINICAL REASONING EVALUATION

- The member will have the patient records during the process and can refer to any section to help explain clinical reasoning.
- The member will describe their clinical reasoning, which is primarily why they did what they did, not just what they did during intervention.
- The administration of the CRT takes approximately 12-15 minutes per patient record.
- The peer assessor may not ask all of the questions. Sometimes a member will answer two or more questions in their discussion.
- The peer assessors will capture information by making notes regarding the member's clinical reasoning. They might return to a question if they need more information.
- The administration of the Clinical Reasoning Tool will be audio recorded.
- The peer assessor may contact the member following the site visit for clarification or additional information if needed.

3.C POST PEER ASSESSMENT

- If the peer assessor has doubts about a member's clinical reasoning in a particular area, or they determine that it is inadequate, the peer assessor will contact the College and upload the audio files. The College will send the audio files to another peer assessor in the same area of practice for an independent second evaluation followed by a discussion between the peer assessors. If the peer assessors do not agree, the original peer assessor will make the decision regarding the member's clinical reasoning.
- The peer assessor's findings regarding clinical reasoning will be included in the Peer Assessment Report.
- If the peer assessor determines that the member's clinical reasoning is inadequate, the assessor will document the areas of practice where it is an issue (background, assessment, management or discharge planning), and the clinical reasoning skills that are missing (collecting information, applying, linking, patient context, options, flexible and reasonable rationale).

- Members will be sent a copy of the report for review and to provide a response for the Quality Assurance Committee.
- The Quality Assurance Committee will review the peer assessment summaries and reports and make decisions accordingly. The decisions will focus on helping the member enhance clinical reasoning through a Clinical Reasoning Remediation Program.