Outcome measures in acute dysphagia

December's Bulletin feature, 'Outcome measures in acute dysphagia', contained points that require clarification with regard to using Therapy Outcome Measures (TOM) in the acute setting

An outcome measure should identify the impact of an intervention. Some individuals with dysphagia receive speech and language therapy input to improve the impairment, increase their functional swallow, reduce impact on social participation and reduce the effects of the impairment on their wellbeing or that of their carer/relative. Intervention aimed at one of these areas may impact on other areas. For example, improving functional swallowing may lead to improved wellbeing. It is equally possible that in some individuals reducing anxiety (improving wellbeing) will lead to improved function. A benefit of TOM over other outcome measures cited in the article is its ability to measure participation and wellbeing.

Jodi mentions the difficulty in measuring participation and wellbeing in an acute setting. While reflecting a person's participation in the environment they are in should be possible (ie, assessing a patient's autonomy, confidence and capability to participate actively in treatment), Jodi's team found this difficult to assess on the TOM scale due to restrictions imposed by their hospital environment and acute episodes of medical illness (such as chest infection) which influence patient participation. We understand some acute sector teams have found this possible. Pam points out that the TOM tool allows users to identify 'not appropriate' if measuring participation is not possible; similarly, if a therapist is unable to make an accurate judgement of emotional wellbeing they can also identify this as 'not appropriate'.

For patients with 'multiple morbidities of which dysphagia is not the primary issue' it is advised that the therapist uses the appropriate adapted scale (of which there are 47) or the core scale rather than the dysphagia scale. By adopting these approaches it should be feasible to use TOM on all clients receiving acute intervention. However, this does mean inputs for dysphagia are not captured on an isolated scale, but form a more holistic multidisciplinary or medical measure rather than an outcome specific to speech and language therapy. TOM can identify two impairments (eg, on the cognition scale as well as the dysphagia scale).

The article suggests a difficulty of using TOM because of patients' inability to participate in setting their own goals or reviewing their outcomes'. A basic principle of TOM is that it is for the therapist to make the judgement following assessment and observation, and where possible discussing this with the client. While all domains can be completed without patient involvement, the acute team trialling TOM felt discussions with the patient were paramount, particularly for accurate assessments of wellbeing – because contact with patients in this setting can often be brief or 'one off' encounters.

Another difficulty identified within Jodi's trial of TOM was in fitting observations of dysphagia impairment and function 'neatly' into one of the predetermined descriptors. The TOM manual explains these descriptors are guides and should be used as 'best fit' descriptors. This is why half points are available to indicate whether someone is slightly better or worse than a descriptor. The manual points users towards the core scale if descriptors are not helpful, demonstrating the flexibility of the TOM tool. The acute team did, however, find scales outlined in alternative dysphagia measures more intuitive for use in the acute setting; therefore, they opted to use an alternative tool rather than default to the TOM core scale. The team acknowledges that with extra time and training it may have been possible to make the TOM descriptors work for them.

The TOM manual and training indicate the importance of practising on 10 patients prior to collecting data to improve familiarity, speed of scoring and reliability. This is in keeping with other dysphagia outcome measures, which also advise group scoring exercises and reliability testing.

An inadvertent error in December's article indicated that TOM has a five-point scale, when in fact it has an 11-point scale (score 0–5 with half scores) over four domains. It has strong reliability and like any other assessment or outcome measure needs to be understood and practised, as detailed in the manual. Unlike other dysphagia outcome measures, TOM does have applicability in settings outside the acute hospital.

In view of its potential application across the profession, Jodi and Pam maintain an interest and dialogue in the use of this measure in the acute hospital and would be happy to hear from other therapists working in the acute setting who are either already or are considering using TOM. ■

"TOM does have applicability in settings outside the acute hospital"

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