**Dysphagia care for adults in the community setting commands a different approach:
Perspectives of speech-language therapists**

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Abstract

Background

Descriptions of community-based speech-language therapy (SLT) dysphagia practices and services are underrepresented in the research literature, despite the prevalence of dysphagia in the community. Due to a globally ageing population, and government drives to support people to remain living at home rather than in hospital or aged care, there is a growing need for SLT services to be responsive to the needs of clients living at home in the community, referred to in this study as community-based clients. Exploration of current SLT services and dysphagia care practices for this population may identify ways services can be designed and enhanced to better meet the needs of clients and carers.

Aims

To explore the nature (i.e. characteristics) of dysphagia services and SLT clinical practices for adults with dysphagia living at home in the community.

Methods & Procedures

Using a qualitative descriptive approach positioned within an explanatory sequential mixed methods design, this study explored SLT services and practices for adults with dysphagia living in the community to further explain and elaborate on findings from an earlier quantitative study. Fifteen speech-language therapists (SLTs) working with community-based clients with dysphagia were recruited using purposive representative sampling. Content analysis was used to explore the data.

Outcomes & Results

The overarching theme of *Community commands a different approach* was illustrated by three subthemes that highlighted how and why a different approach to dysphagia care in the community setting was necessary: 1) *Skills and mindset require adaptation in the community context*; 2) *Values and approaches are different in the community context*; and 3) *Organisational influences impact service delivery in the community context*. From the data, it is apparent that the work undertaken in the community setting differs from dysphagia care in other settings and requires adapted SLT skills, values and approaches that encompass holistic care, client autonomy and carer engagement. SLT practices are also informed by organisational influences such as policies and resourcing, which in some services were enablers while for others these presented challenges.

Conclusions & Implications

Community-based SLT services must continue to foster flexible, responsive practices by SLTs to ensure the needs of clients and carers are met now and into the future.

What this paper adds***What is already known on this subject***

While much is known about SLT dysphagia practices and services in a range of settings including acute hospital and aged care, there exists a paucity of literature about the community setting where clients and carers are managing dysphagia at home (known as community-based clients).

What this study adds

This study identified the practices of SLTs working with community-based clients with dysphagia and highlights the various ways SLT practices and services are different in the community setting compared to other settings. Further it identified how these services may influence provision of dysphagia care for clients and their families.

Clinical implications of this study

Understanding the nature of community-based dysphagia care, with its strong emphasis on holistic care, client autonomy and carer engagement, is needed to ensure SLTs are suitably prepared to work in this setting.

Introduction

Speech-language therapists (SLTs) play a key role in supporting people with dysphagia, and increasingly so in community settings, where the prevalence of dysphagia is estimated to be between 11-38% (Holland et al., 2011; Kawashima, Motohashi, & Fujishima, 2004; Lindgren & Janzon, 1991; Roy, Stemple, Merrill, & Thomas, 2007). Due to ageing populations globally (United Nations, 2015) and government drives to support people to remain living at home, rather than being admitted to hospital or placed in aged care (Bliss & While, 2014; Department of Health, 2015), there is a growing need for speech-language therapy (SLT) services to be responsive to the needs of communities. An important first step in becoming more responsive is to examine current SLT services and dysphagia care practices that occur for those living at home in the community, known as community-based clients. In this study these individuals are seen as having distinct needs to residents living in aged care. Examining the characteristics of services provided to community-based clients may help reveal potential service gaps, and ways in which the needs of clients and carers managing dysphagia within the home can be optimised.

To date, descriptions of community-based SLT dysphagia practices and services are underrepresented in the research literature. This is in stark contrast to other areas of SLT practice such as aphasia (Brown, Worrall, Davidson, & Howe, 2011; Page & Howell, 2014; Rose, Ferguson, Power, Togher, & Worrall, 2014; Verna, Davidson, & Rose, 2009), which have a strong community research base. Only three studies have provided insights on SLT dysphagia practices in the community (Howells, Cornwell, Ward, & Kuipers, 2019; Rumbach, Coombes, & Doeltgen, 2018; Steele et al., 2007), with the last two examining dysphagia practices across a range of settings (e.g. inpatient, outpatient and community) (Rumbach et al., 2018; Steele et al., 2007). In both studies, service characteristics and differences across settings were not reported consistently, making conclusions about community SLT practices difficult to establish.

The recent study by Howells, Cornwell, Ward and Kuipers (2019) was the first focused investigation to explore SLT dysphagia practices and services for those living at home in the community. Using an online survey, the authors obtained information about dysphagia services as well as dysphagia assessment and management practices from 144 SLTs working with community-based clients in Australia. A key finding was that SLT clinical practices appeared in line with a more traditional medical model, with a strong focus on the underlying impairment causing dysphagia and little focus on the psychosocial

dimensions of care. For example, less than half of the participants said they referred or encouraged clients or caregivers to access support or social groups and few incorporated social participation or client well-being aspects in their treatment. The study concluded that the needs of clients and carers may not be being fully met by services and clinicians.

While a clearer understanding of community-based dysphagia services and SLT clinical practices is beginning to form, an apparent limitation of the three available studies to date is that all have relied on survey methodologies. While surveys enable systematic collection and analysis of typically quantitative information (Leeuw, Hox, & Dillman, 2012), they do not allow for in-depth description or exploration of phenomena in the same way as qualitative research (Berg & Lune, 2017). In the current study, the research focused on understanding the *how* and *why* of service provision for adults with dysphagia living in the community. Therefore, the aim of the current study was to conduct an in-depth exploration of dysphagia services and SLT clinical practices for adults with dysphagia living at home in the community, to further explain and elaborate on the findings from the earlier quantitative phase by Howells et al. (2019).

Methods

A qualitative descriptive approach articulated by Sandelowski (2000) was used to explore SLT services and practices for adults with dysphagia living in the community. It was positioned within an explanatory sequential mixed methods design, whereby quantitative data is first collected, followed by qualitative data (Ivankova, Creswell, & Stick, 2006). The purpose of this methodology is to use the qualitative results to further explain and interpret findings from the quantitative phase (Ivankova, Creswell, & Stick, 2006). The current study represented the follow-on step from the earlier published quantitative survey of Howells and colleagues (2019). A qualitative descriptive approach was adopted as it is specifically suited to “obtaining straight and largely unadorned answers to questions of special relevance to practitioners and policy makers” (Sandelowski, 2000, p. 337). This approach enabled exploration of the clinical practices and service contexts of SLTs who work with community-based clients with dysphagia. The resulting descriptions were based on the information provided rather than abstract interpretation of the data. Ethical clearance was obtained through the relevant university human research ethics committee.

Participants

Participants were identified through the recruitment process of the previously published survey (Howells et al., 2019), where survey respondents were asked to indicate their willingness to participate in a subsequent study about community dysphagia care. From that

cohort, a purposive representative sampling approach was used to recruit participants for the current study. This sampling approach was informed by the results of the published survey research which highlighted that SLTs work with adults with dysphagia living at home in the community in a variety of locations, service types and settings (Howells et al., 2019). The sampling dimensions used ensured a range of locations (metropolitan, regional and rural/remote), service types (public, private and NGO), settings (client's home, community health centre, outpatient clinic, hospital) and states (across Australia) were represented across participants. Recruitment continued until representation across all sampling dimensions was achieved. This sampling strategy ensured a diverse selection of participants to capture a range of perspectives (Palinkas et al., 2015). A summary of the sampling parameters is outlined in Table 1.

Table 1 about here

From an available participant pool of 40 SLTs, 15 SLTs were identified and invited to participate. All participants provided informed, written consent prior to the interview. Participants were all female and ranged in age from 29-57 years with a mean of 40.7 years (SD = 10.7). Their years of experience working with adults with dysphagia ranged from 1-30 years, with a mean of 10.3 years (SD = 7.9).

Procedure

Individual, semi-structured interviews were conducted with each participant via telephone by the lead researcher (SH). Interview questions were informed by areas requiring further explanation from the preceding quantitative survey completed by the research team (Howells et al., 2019). The questions were centred around clinical practices and service characteristics for people with dysphagia, including topics such as policies, procedures and barriers/enablers to service provision. A topic guide was created, pilot tested with one SLT and further refined accordingly. Participants were provided with the topic guide in summary form via email prior to the interview to encourage reflection and richness of data (Patton, 2015) (Appendix 1).

Each interview lasted between 30 – 50 minutes and all interviews were audio recorded and later transcribed. Data collection occurred over a 4-week timeframe. A reflective journal was kept by the interviewer following each interview, as described by Ortlipp (2008), to encourage transparency in the research process. Journal entries comprised of both researcher critical self- reflections on the process and practice of interviewing as well as a summary of the content each participant spoke about. The content summaries enabled the primary researcher to identify when data saturation was considered to be reached, which is the point at which no new information is being generated by participants (Fusch & Ness,

2015). Within the last 5 interviews conducted, no unique or novel concepts were raised by these final interviewees.

Data Analysis

Qualitative content analysis was undertaken as described by Graneheim & Lundman (2004) and Elo & Kyngäs (2008). This began with the lead researcher (SH) reading the transcripts several times to become immersed in the data and familiar with the participants' perspectives, then open-coding two transcripts to identify potential codes and categories (Elo & Kyngäs, 2008). During this open-coding process, "meaning units" were extracted from the participants' transcripts, condensed and then assigned a code (Graneheim & Lundman, 2004). To maximise accuracy and ensure confidence in coding, a member of the research team who was not involved in the interviews (PC) also completed open coding of two transcripts. Three members of the research team (SH, PC, & EW) then met to discuss the coding of these transcripts, refine the codes and reach consensus of those to be used in future coding. The lead researcher then completed coding on the remaining transcripts and sought input from the research team in instances where there was redundancy or lack of clarity.

A list of categories was then created, and related categories were grouped and collapsed to form higher order headings, which ultimately became subthemes in line with recommendations by Elo & Kyngäs (2008). During this process, comments made by participants that aligned with categories were noted, and attributed to the participant's identifier to further ensure trustworthiness of the data (Elo & Kyngäs, 2008). The refinement and grouping of categories ultimately led to the development of subthemes and an overarching theme from the data set (Graneheim & Lundman, 2004).

Results

Content analysis revealed one overarching main theme comprised of three subthemes. These described the clinical practices of SLTs working with adults with dysphagia living at home in the community, as well as the clinical services within which they worked. The overarching theme of "*Community commands a different approach*" reflected participants' views that there are unique benefits and challenges associated with working with community-based clients with dysphagia. Specifically, they spoke about a variety of ways in which their approach to dysphagia care in the community setting was different from approaches taken in other settings. The overarching theme arose from three subthemes that highlight *how* and *why* a different approach is needed: 1) Skills and mindset require adaptation in the community context; 2) Values and approaches are different in the community context; and 3) Organisational influences impact service delivery in the community context. The views of all

participants were expressed across each subtheme. Each subtheme contains categories that explain the participants' views in detail. The structure of the data is outlined in Figure 1.

Insert Figure 1 about here

Subtheme 1: Skills and mindset require adaptation in the community context

Participants described how their practices in the community setting were different to other settings. Most participants saw clients in the client's home, though irrespective of the location of service, all acknowledged that clients who live at home experience challenges that are different to clients in other settings (e.g., acute hospital or aged care), such as meal preparation or managing dysphagia when socialising or going out for a meal. These unique client differences meant that at times, SLTs needed to adapt both their skills and mindsets for care to be appropriate for the setting or client group, and responsive to the ever-changing needs of clients and families.

Dysphagia practices influenced by client presentation / condition

SLTs spoke about how their practices were not a 'one size fits all' approach and were influenced by either the client's presenting issues and/or diagnosed condition. SLTs emphasised that in the community setting the individuality of each client and their home situation was apparent, and SLT management should reflect this. SLT 4 commented:

"Everyone's very different. And you know, that's what it should be. Everyone should have an individual practice based on that particular person." (SLT 4)

This included taking a flexible approach dependent on clinical, client or family concerns:

"We see them [clients] as often as needed. Some people I would say "I'm just going to be monitoring you on a monthly basis." Or other people I would say "Right, well I'm going to come back and see you." We're very flexible with what's needed depending on the family and how they're coping and what the severity is." (SLT 12)

The need to individualise services in terms of the frequency, or the nature of the services (e.g. education vs active rehabilitation) was noted to be influenced by diagnostic groups alongside personal factors. As SLT 10 stated:

"[what the SLT does] really does depend on what they've [the client has] got. For example, for someone with COPD it's early intervention and preventative work. It also depends on how motivated they are or how often they cancel their appointments." (SLT 10)

Where SLTs were working with clients with progressive neurological conditions they highlighted the importance of providing education and tailoring their service to disease stage

and presenting condition. For example, SLTs reported being more involved with clients and their families as the disease progressed. As SLT 6 explained:

“Due to the nature of Parkinson’s, they may need a little bit more advice about texture modification in the future... So for progressive neurological, I tend to have that more frequent, supportive role.” (SLT 6)

SLTs require a different skill set

Some participants stated that working in the community and particularly in client’s homes, required a different skill set to other settings, and this was particularly apparent for those who had previously worked in an acute setting. At times these skills related to skills used in other healthcare settings but were drawn upon more so in the community setting, such as education as SLT 2 describes:

“What I find is the difference between my job and when I was working in acute, is that a lot of my job is trying to educate my patient and their carer or family as to why they need to make the certain changes that they do and trying to find ways for them to stay compliant with those recommendations.” (SLT 2)

Other SLTs described the knowledge gap that can exist between hospital and community-based SLTs:

“... When I first stepped into the position I was like “Oh what is this job? What do you mean, what is it? What do I do?” and I think if hospital speech therapists could understand what it’s like day to day working in community health, there’d be a lot more referrals and a lot less stress on the hospital system in terms of managing those clients.” (SLT 5)

The skill adaptations required in the community also transcended SLT clinical skills and related to managing the social complexities of being in the client’s home and making realistic client recommendations:

“Any kind of community service is never straight forward. I do so much social work it’s insane. There’s so much social complexity for people living in their community. In a hospital environment it’s so much more contained and you’ve got your social workers and you work on safe discharge. But in the community, things vary. Like, there’s domestic violence... it’s so much more than this tiny little issue.” (SLT 5)

Participants also emphasised the flexibility, creativity and resourcefulness required in community-based SLT practice compared with hospital-based work. Several participants spoke about the flexible approach they needed to employ in the community compared to other settings:

“When people are in hospital I’ve found they’re more accepting of recommendations from clinicians. They take it in turn and go “yep, this is part of medical management.” But when a client is at home it’s very different. They’re like “well these things work for me” and “I’m back in a place where I need to be normal.” So you can’t be so rigid in your recommendations, you have to be flexible and work with the client.” (SLT 13)

It was also apparent from the interviews that participants regularly exercised creativity and resourcefulness to achieve sustainable outcomes for clients:

“... We had a lady the other day and she didn’t have any way of measuring, and we just got all these different types of cups and spoons and just tried to figure out a way of making up the 185mL for this thickener... Luckily I had an empty container in the back of the car that I could use! We’ve taken people to buy blenders before, gone through and had a look at what frozen meals are suitable for them ... seeing what it is, what they can afford, what they can get in and what they like and how we can change it all for them.” (SLT 15)

One participant also highlighted that in the community, the complex realities of clients’ lives also challenged priorities, which would ultimately require a different SLT approach:

“A client doesn’t often see their swallowing as much of a concern as you do... A lot of these people are tired, always tired. I’m sure there’s a huge amount of undiagnosed depression as well. A lot of them have recently lost (driving) licences or they’ve got other medical priorities that make swallowing not seem that big of a deal. Their carer may be in even more compromised health than they are. So sometimes when you shake it all down, swallowing is not always flashing at the top of their head...” (SLT 6)

Participants also emphasised that the community SLT skill set was more ‘big picture’ and took an overall view of the client’s world:

“I’ve cooked meals in the homes with them and taught them how to scramble eggs so that they’re moist enough. I get to sit with them [the client] and assess their swallow at their dining table with their dog eating the crumbs off the floor. You pick up so much when you’re in that home. The carer is hovering about. I can look in their fridge and hold up something and suggest it. I can go into their medicine cupboard and see do they have any Biotene [dry mouth product] left.” (SLT 6)

Interactions with primary care and community agencies

All participants spoke about the importance of interactions with other health professionals, either within their organisation’s team or across organisations. Many also mentioned the importance of linkages with community-based services and agencies.

“We’ve got [access to] a whole range of services so it depends what’s happening for someone. If there are social issues, I might make a referral to council or aged care assessment for services. There might be a need for counselling. If they seem to potentially have a neurological condition without being diagnosed, I’ll write to their GP to suggest a referral to a neurologist. I’ll sometimes refer people to disease specific organisations like the MS Society...” (SLT 11)

Some participants spoke about the benefits of being co-located and collaborating with other health professionals:

“We’ve had instances where the dietitian and I will go around their [the client’s] local supermarket and label the aisle and the product that is safe for that client.” (SLT 6)

Even those who did not routinely work alongside other professionals explained that a multidisciplinary focus with regular communication was vital:

“I’ll get in contact with the dietitian if I need to, and/or physio so we also work in together. I send them copies of my reports as well as to the GP. We often do that ... we’re often in contact with each other and we know who’s going in and what’s happening. It’s a real team approach even though none of us are in there at the same time.” (SLT 4)

Many participants spoke of the range of organisations outside their own that they could refer clients with dysphagia to, which included referrals to other health professionals and services. While some participants found interacting with other professionals and agencies outside of their organisation to be straightforward, other participants highlighted challenges, particularly within the private sector:

“More integration is needed between private specialists within the community and GPs [general practitioners / family doctors], allied health and care providers.” (SLT 11)

Subtheme 2: Values and approaches are different in the community context

Participants shared rich information about their values and approaches when working with community-based clients with dysphagia. This involved seeing the overall view of the client, thinking holistically about their care and not just considering but valuing the client and carer’s preferences in decisions about care.

Holistic viewpoint

It was apparent that participants felt a holistic viewpoint was important when working with adults with dysphagia at home, as well as with their caregivers. Many spoke about this as central to their clinical practice.

“I think seeing dysphagia with the whole person and what’s going on for them is one of the most important things. It really comes back to what else is happening for them and I tend to be very broad in looking at what’s happening for someone.” (SLT 11)

Many identified that it was also necessary to consider the client beyond their swallowing impairment, to consider all aspects of health and wellness, and optimisation of this where possible. As SLT 4 described:

“If they’re eating better and swallowing better, and they’re not aspirating, and their diet is improving, they’re gaining weight then they’re going to go and mobilise a lot better. So it’s a knock on effect with all the other allied health. And then the social worker would say “well they’re a lot happier now!”” (SLT 4)

One participant identified that working holistically may also be influenced by individual SLT preferences and the service culture:

“Like any service, it depends on the clinician and how they view clinical care and what they’re willing to put in. We’ve got really dedicated, holistic clinicians that put the client first, are really person-centred and aren’t like “Oh but you have to have thickened fluids or I’m not going to see you again.” (SLT 13)

Participants noted that part of the holistic approach included considering the role other health professionals could play in the support of clients and complementing that with practical supports that could be provided by the SLT at home. As SLT 10 described:

“It’s about looking outside the square to see how else we might help that might actually have some sort of impact. Either by identifying referral to other health professionals ... as far as food preparation goes, and ideas for managing better at home.” (SLT 10)

Client autonomy

Most participants emphasised the importance and value of client autonomy when working in the community setting. Many felt their service was designed with the clients in mind and that the SLT role was firmly to support clients and carers, depending on the client’s dysphagia priorities. As SLT 8 stated:

“Clients are the driving force behind how our service is delivered; it’s very client-centred and we do what the client wants, within reason.”

Many acknowledged that it was both difficult but important to strike a balance between the client’s dysphagia priorities and safe swallowing practices, recognizing that the client is free to make informed choices:

“Just optimising oral intake so that the person enjoys it as much as possible. That they’re as safe as possible, and if they chose not to have that as safe as possible well then, it’s an informed choice and they understand the risks. So whatever the client wants from me in terms of dysphagia management, is what I’m there to provide.” (SLT 5)

Participants also highlighted that autonomy in the community context requires clients and carers to take responsibility for their healthcare, but that this requires a degree of availability on the part of the SLT:

“I’ve always encouraged them to ring me. So I’ll often get a phone call from someone’s daughter or wife just to ask me a question about something. I’ll go through it on the phone with them... I’ve tried to establish a really open rapport so that they can feel comfortable to ring me about anything and they do.” (SLT 4)

As such, community SLTs emphasised the importance of general education and empowerment, but also to remaining available as therapists:

“We want to be making sure that our patients are really thriving in the community. That they’re safe and that what we can offer them helps them to live their best life; enjoy the quality of life they have, enjoy the food and drinks that we can have them managing safely. The goal of our service is to empower them with education so that they don’t become reliant on us. That they can quite confidently manage their dysphagia and just contact us if something changes.” (SLT 14)

Carer engagement

Across all participants, the role of the paid and unpaid carers was discussed. Most identified that this was a greatly valued role, and central to maintaining client health overall, as well as implementing dysphagia recommendations:

“Without the carers, I don’t think anything would work. They’re so vitally important in the community whether that be the case managers ... or daughters, wives, husbands – phenomenal people... They’re all incredibly important in terms of education, compliance to recommendations and supporting informed choice and quality of life decisions.” (SLT 5)

Conversely, in cases where there were no carers, the words of SLT 2 demonstrate the difficulties that could arise:

“I’ve found that clients who don’t have a carer or family support helping them, tend to not go that well with whatever recommendations they’re on.” (SLT 2)

Some participants shared how the pivotal role of the carer influenced their own approach to clinical practices, with the carer seen as a key part of the team supporting the client, receiving education and training and making collaborative decisions:

“The family are very involved with my client. It’s not just me coming in, it’s like “Okay, we’re a team now and I’m seeing your husband and you’re part of this team”. I want them to know we’re all on the same level and I’m not this professional whatever that’s going to come in and tell them what to do. We make decisions together – the patient, myself, the carer. We always do it that way.” (SLT 4)

Subtheme 3: Organisational influences impact service delivery in the community context

Organisational influences such as policies and resourcing were described by participants as central to how their service operated and therefore informed the care they could undertake with clients and families. In some cases, the organisational influences positively influenced service delivery, while for others these presented barriers to optimal care.

Diverse structures and policies

The influence that various service structures, governance and policies had on SLT service provision for community-based clients with dysphagia was apparent in each interview. In some cases, policies supported optimal dysphagia care through being flexible and tailored to the individual needs of each client:

“We are very autonomous. We don’t have someone above us saying “right, well now you’re not to do that or you are able to do that.” We can really see people as often as we want them to be seen.” (SLT 12)

However, for others this was not the case:

“Our health executive team has lost the needs of community health. It’s all about supporting the hospital and their business, managing people that are sick. But of course, we’re trying to get them before they get too sick.” (SLT 3)

It appeared that there were numerous pressures on community-based SLT services and that hospital-based changes impacted how and where community-based clients were seen:

“Our hospital services have changed recently. Everything was hospital-based, for outpatient services, but now, if you’ve had an admission you will get some appointments associated with your admission. But apart from that, nothing. That’s really affecting our service because everything from the local hospitals is getting pushed through to us.” (SLT 10)

Service capacity and resources

Funding was a recurring topic for participants, noted as both a service challenge and a service enabler, and encompassed everything from staffing through to physical resources available for SLT care. Participants described how their services were funded, with many services accessing multiple funding sources, which influenced the type of services they could provide to community-based adults with dysphagia:

“[There are] lots of different funding streams, it’s constantly impacting on how you do things. Even though broadly the pattern [of service] stays the same, the frequency and shape of it change a bit depending on funding.” (SLT 6)

Unfortunately, multiple funding streams also resulted in a number of inconsistencies in services provided. For example, for some adults living at home with dysphagia, the cost of thickened fluids was covered by the hospital, while for others, this cost was incurred by the client and family:

“... If they’re put on thickened fluids in the hospital, they can get it covered (financially). [Others] are forking out for that year in and year out” (SLT 9)

Resource constraints were also mentioned by several participants, and reflected in limited equipment and physical resources, such as therapy rooms in health service facilities. Funding for equipment appeared to be limited in community settings:

“In community, you’re not particularly well-funded for resources, say equipment and therapy materials. I’ve come from different rehab services, so I’ve got a lot of resources. Otherwise I would’ve been stuffed! New and upcoming equipment that’s available in hospitals, like sEMG for example, we don’t have funding for that. We are trying to set up an equipment loan pool with dysphagia stuff. So meter-flow cups and everything like that. Looks like it’s going to have to be community funded so ... (laughs). There are a few more hurdles in community than I’ve had in hospital.” (SLT 13)

Participants emphasised the need for more funding for community-based clients; to keep them supported at home, and out of hospital:

“There needs to be more funding in the community as a whole. Not just for dysphagia patients, but all of the people who come through. I think keeping them out of hospital, providing as much support to keep them in the home is where resources should go.” (SLT 15)

SLT staffing as well as that of the multidisciplinary team and allied health assistants was also discussed by participants as a factor driving how community-based services for adults with dysphagia are delivered. SLTs explained numerous pressures on their time, such as how their

work day was not just busy with seeing clients, but also with travel and associated administrative tasks:

“For instance today, I had an over one hour drive between two clients so that does impact on what you can achieve.” (SLT 6)

Noting the multidisciplinary nature of community-based SLT practices, it was recognised that other community therapist workforces’ impact on the delivery of SLT services. For example, the role of other health professionals in the care of community-based clients with dysphagia can be negatively impacted by a lack of available health professionals to refer to and see clients with:

“Sometimes we’re not able to see clients in a multidisciplinary or interdisciplinary fashion... because the other allied health don’t have enough FTE. OT can have a waitlist of over a year and it’s similar for physio.” (SLT 13)

In response to shortages of community-based SLTs and other service providers, some SLTs described utilising an allied health assistant workforce to support clients with dysphagia in their services. This sometimes supplemented but usually enhanced the care provided by the SLT service. For example, through doing rehabilitation exercises and education:

“We also do utilise our allied health assistant quite a bit if we’ve got a patient requiring dysphagia rehab. We are doing more training with our AHAs now to be able to implement that in addition to face to face SLT time... I know they can spend more time with those patients doing the explanations ... They can give the patients time to practice, which to be honest, is more beneficial than us sitting across the table from a patient giving them a handout. I think they need someone to invest time in preparing what they need to prepare at home.” (SLT 14)

Discussion

The current study has provided in-depth insights into the clinical practices of SLTs working with community-based clients with dysphagia and their carers, as well as rich information about the services they work within. Emerging from the interviews was a clear story that the community setting commands SLTs to approach dysphagia care differently as they are seeing clients in the ‘real world’. The findings shed light on the various ways SLTs adapt their skills and mindset when working with community-based adults with dysphagia and their carers, and how dysphagia care in the community encompasses different values and approaches compared to other clinical settings encompassing the client’s social circumstances and practical supports. Prominent in the participants’ perspectives was how the services within

which they worked influenced the care they could provide to clients and carers, and all discussed aspects of their service that enabled and hindered optimal care.

Participants spoke about how they felt dysphagia care in the community was distinctly different to SLT practices in other settings, and this required adaptation of their skills and mindset. Many shared previous experiences of working in the acute hospital setting and contrasted their community experience as being more ‘hands on’. In large part, the adaptation of SLT skills and mindset revolved around where and how the care occurred; most participants saw clients in the clients’ home. These SLTs overwhelmingly identified the value of seeing the client’s ‘real world’, which many viewed as an opportunity not easily afforded in other clinical settings. They explained that the home setting enabled practical dysphagia support (e.g., cooking demonstration or pantry discussion), greater insights into other challenges the client might be living with (e.g., complex family or social circumstances), and more meaningful understanding of how the client and carer could be supported beyond the swallowing impairment (e.g., with referrals to other professionals or agencies). While the current qualitative design provided greater insights into dysphagia clinical practices and services in the community than previous studies, the perception that home-based care may be optimal for supporting clients and carers is not new. A meta-analysis assessing the effect of ‘hospital in the home’ services found reductions in mortality, lower hospital readmission rates and costs, and increased patient and carer satisfaction (Caplan et al., 2012). Research conducted with adults with traumatic brain injury and their significant others explored perspectives consumer perceptions of day hospital versus home-based intervention and found that both clients and their significant others perceived home-based therapy as more relaxing, normal, satisfying, effective and generally preferable (Doig, Fleming, Cornwell, & Kuipers, 2011). It appears that the home environment may be optimal for clients, carers and clinicians alike. However, how SLTs undergo this service model adaptation, and whether additional or explicit support is needed during this transition, requires further investigation.

A key finding from this study was the notion that SLT values and approaches are different in the community. Particularly, many participants felt providing holistic care and psychosocial support for people with dysphagia and their families was needed in the community and core to community practice. This is a distinctly different approach to the medical model often found in the acute hospital setting (Armstrong, 2003). Reinforcing the notion that psychosocial care is central to community SLT practice, a recent study that investigated SLT beliefs regarding quality of life in dysphagia found SLTs believed that “quality of life is more appropriately addressed by SLTs based in a community setting

because in the acute setting ‘care is often focused on acute medical status’” (Moloney & Walshe, 2019, p. 45). Whether SLTs have the skills or confidence to provide holistic care and psychosocial support was not clear from the current study, however the work of Moloney & Walshe (2019) found SLTs lack confidence to support quality of life issues in dysphagia and report a lack of available training and education during university study and post-graduation. Further research exploring SLT confidence and capability to undertake approaches, such as holistic care and psychosocial support, in community-based dysphagia care is warranted. It is possible that SLTs transitioning to working in the community setting would benefit from practical education and training to adapt their practices and approaches to enable provision of holistic care and psychosocial support.

The current study highlighted that a major driver influencing SLT dysphagia practices is the organisational influences within the services they work. Several relevant factors which affect service provision were identified, including service governance structures, policies and resources. While some SLTs reported funding as a service enabler, many SLTs also reported significant funding constraints. Funding constraints were reported to impact staffing levels, both within SLT and other professions, as well as availability of physical resources and equipment. This finding may not be unique to dysphagia care in the community; Rose et al. (2014) found the same challenges were reported by SLTs working in aphasia rehabilitation. While these findings may be relevant to all areas of SLT practice, they present important considerations in the delivery of optimal care.

Limitations

This study represents clinical practices of the Australian healthcare setting which is in large part, publicly funded. While this mirrors many international settings including that of the United Kingdom, the generalisability and transferability of findings to other contexts where publicly funded services are not the dominant mode of service delivery may be limited.

Conclusion

This study has provided insights into the work undertaken by community-based SLTs working with adults with dysphagia who live at home. It is apparent that the nature of work undertaken in the community setting differs from other care settings, such as the acute hospital setting, and requires adapted SLT skills, values and approaches that encompass holistic care, client autonomy and carer engagement. This raises implications about how SLTs are being supported in their transition to community-based work. SLT practices are informed by organisational influences such as policies and resourcing, which in some services may enable optimal care, and for others may present challenges. Services must

continue to foster flexible and responsive SLT practices tailored to the individual with dysphagia to ensure the needs of clients and carers are met now and into the future.

Table 1. Purposive variation sampling characteristics (*n* = 15).

Demographic	Sampling parameter	Number of participants	Participant ID
Service type	Public	10	SLT1, SLT2, SLT3, SLT7, SLT10, SLT11, SLT12, SLT13, SLT14, SLT15
	Private Practice	2	SLT4, SLT9
	Non-government organisation	3	SLT5, SLT6, SLT8
States	Queensland	7	SLT1, SLT3, SLT4, SLT6, SLT8, SLT10, SLT14
	New South Wales	2	SLT9, SLT13
	Victoria	3	SLT5, SLT7, SLT11
	Tasmania	1	SLT2
	South Australia	1	SLT12
	Western Australia	1	SLT15
Service locality	Metropolitan	7	SLT5, SLT8, SLT9, SLT12, SLT13, SLT14, SLT15
	Regional	6	SLT3, SLT4, SLT6, SLT7, SLT10, SLT11
	Remote +/- Rural	2	SLT1, SLT2
Setting where clients with dysphagia predominantly seen by SLTs	Client's home	11	SLT2, SLT3, SLT4, SLT5, SLT6, SLT8, SLT9, SLT11,

		SLT12, SLT13, SLT15
Community health centre / other location in community	2	SLT7, SLT10
Outpatient rehabilitation unit / outpatient hospital clinic	1	SLT14
Acute hospital	1	SLT1

Figure 1. Visual of overarching theme, subthemes and categories that arose from the data.

Overarching theme	Community commands a different approach							
Subthemes	Skills and mindset require adaptation in the community context			Values and approaches are different in the community context			Organisational influences impact service delivery in the community context	
Categories	Dysphagia practices influenced by client presentation / condition	SLTs require a different skill set	Interactions with primary care and community agencies	Holistic viewpoint	Client autonomy	Carer engagement	Diverse structures and policies	Service capacity and resources

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Appendix 1

Participant Topic Guide

Demographics:

1. How long have you been working clinically as a speech pathologist with adults with dysphagia who live at home?
2. What is your age?

Questions:

3. Could you describe what a typical patient journey into and through your service may look like for a client with dysphagia who lives at home?
4. Could you describe if and how that approach changes for different population subgroups?
5. What do you perceive are the overarching objectives/goals of your service for community clients with dysphagia?
6. What are the major drivers and/or factors that influence how your service is designed and delivered for clients in the community?
7. Can you describe if you feel the community service that you can offer is adequate for your clients' needs and why?
8. If you could spend some time talking someone who controls funding for community services, what would you tell them, or ask for, if you could?
9. Is there anything else you would like to tell me about?