Supplemental Online Material

Speech and language therapy service provision to UK intensive care units: a national survey

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Appendix A: Survey

RCSLT Tracheostomy CEN National Survey of SLT service provision to Critical Care

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Page 1: Participant Information

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The RCSLT Tracheostomy CEN are carrying out a survey to establish the current status of SLT service provision to critical care patients nationally. The aims are:
1. To benchmark SLT service provision nationally
2. To identify factors which might explain differences in SLT service provision
3. To identify unmet needs and good practice
4. To inform recommendations for SLT staffing levels in critical care and feedback to the Intensive Care Society

Questions are based on the GPICS (Guidelines for the Provision of Intensive Care Services) recommendations which form national standards and the basis of regional critical care peer review. The survey should take you approximately 15 minutes to complete.

Involvement in this survey is completely voluntary and you can withdraw participation at any time up until the point you press submit. Although the survey is anonymous, we do ask for information about your hospital and NHS Trust, this is so that we can ensure there is no duplication and analyse the impact of location/size of hospital on SLT service provision. The names of hospitals and NHS Trusts will not be used in any outputs from this survey which should help to ensure that you remain unidentifiable. All the information gained will be kept securely and for research purposes only. The research will be written up in a report, submitted for publication and used to contribute to the next revision of the GPICS. The data produced may also be submitted to a secure data repository where it will be kept for a minimum of 10 years, this will allow the anonymised information to be accessed and used for future research.

By continuing and completing this survey you are consenting to proceed with this study and the data being used for the purposes outlined above. You are able to withdraw from the study at any point up until pressing submit. Following submitting the survey, data cannot be withdrawn as the data is anonymous and the analysis will have already begun.

Please note:

- One survey should be completed for the paediatric critical care service and one survey for the adult critical care service per trust or hospital to avoid duplication
- In order to complete this survey you will need information about your service (e.g. numbers of referrals, number of FEES completed, staffing levels etc). We suggest that you complete this survey at a time when you have easy access to this information.

Thank you for your time
RCSLT Tracheostomy CEN Committee: S Wallace, S McGowan, C Iezzi, A-L Sutt, C Mills, A Ginelly, V Thorpe, R O'Mahoney, C McDonald, E Probert
If you have any further questions about this study please contact Claire Mills: c.s.mills@leeds.ac.uk

Ethical approval has been sought from the University of Leeds School of Medicine Research Ethics Committee (SoMREC/SHREC project number 18-007).

Page 2: Background

1. Are you completing this survey for your paediatric or adult service?

- ○ Paediatric
- ○ Adult

2. Hospital

3. Trust

4. How many critical care beds of each specialty do you have in your hospital? (please exclude ward based HDUs)

	Number of beds
General	0
Neuro	0
Spinal	0
Cardiothoracic	0
Burns	0
Paediatric	0
Neonatal	0
Other (please specify)	0

Page 3: Response and Access to SLT

5. Is your SLT critical care service sufficiently resourced for?:

	Yes	No
Communication	○	○
Swallowing	○	○
Tracheostomy weaning advice	○	○

a. If your SLT critical care service is sufficiently resourced, how did you achieve this?

b. If your SLT critical care service is not sufficiently resourced, why not?

6. Do SLT have a daily presence (5 days) on critical care?

○ Yes

○ No

7. Do you provide weekend cover for critical care?

○ Yes

○ No

8. Do you provide bank holiday cover for critical care?

○ Yes

○ No

9. Do you see patients by request only (on referral)?

○ Yes

○ No

10. Which types of critical care patients do you see? (please select all that apply)

- [ ] Level 3
- [ ] Level 2
- [ ] Level 1
- [ ] Post-extubation
- [ ] NIV
- [ ] Trache-ventilated
- [ ] Trache post-ventilation
- [ ] Intubated

11. Do SLT see **ALL** tracheostomy patients in critical care?

- ( ) Yes
- ( ) No

a. If you don't see all tracheostomy patients, why not?

12. Do other staff groups manage patients that you think should be seen by SLT?

- ( ) Yes
- ( ) No

a. If yes, please give details

13. How many sessions (half days) of SLT do you actually provide (include patient contact, teaching, MDT meetings etc) in your critical care units each week? *e.g. one full-time SLT would be 10 sessions*

	Number of sessions provided per week
General	

Neuro	
Spinal	
Cardiothoracic	
Burns	
Paediatric	
Neonatal	
Other (please specify)	

a. What percentage of these sessions are directly funded by critical care?

- 0 %
- 1-25 %
- 26-50 %
- 51-75 %
- 76-99 %
- 100 %

14. How many sessions (half days) of SLT do you think are really needed in your critical care units each week?

15. How many SLT staff do you think you would need to provide a good 5 day week service for communication, swallowing and tracheostomy weaning in your hospital's critical care units?

16. How many staff do you have of each banding working in critical care?

	Whole Time Equivalent
Band 8c	0

Band 8b	0
Band 8a	0
Band 7	0
Band 6	0
Band 5	0
Band 4	0
Band 3	0

Page 4: Referral and Assessment

17. On average, how many critical care referrals do you get per month?

18. Who do you get most of your referrals from?

- [ ] Nurses
- [ ] Doctors
- [ ] Physiotherapists
- [ ] Dieticians
- [ ] Advanced Critical Care Practitioners
- [ ] Occupational Therapists
- [ ] Other

a. If you selected Other, please specify:

19. Do some staff refuse to refer to SLT

- ( ) Yes
- ( ) No

a. If they do refuse to refer to SLT, please explain

20. Is under-referral a problem?

- Yes
- No

a. If under-referral is a problem, please explain

21. Do you think referrals are timely?

- Yes
- No

a. If referrals are not timely, why is this?

22. Are patients with a tracheostomy referred once the sedation hold is commenced?

- Yes
- No

a. If patients are not referred when the sedation hold is commenced, when are they usually referred?

23. On average, how long does it take SLT to respond to new referrals in days?

24. Do you have access to FEES for critical care patients?

- Yes
- No

a. If you do have access to FEES, on average how many working days do people have to wait for FEES assessments?

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- >10

b. If you do have access to FEES, approximately how many FEES do you carry out in critical care each month?

c. If you don't have access to FEES, why not?

25. Do your critical care units use Passy Muir Valves?

- Yes
- No

26. If you do use PMV, are you involved in the assessment?

- Never
- Rarely
- Sometimes
- Often

- Always

27. Do your critical care units use sub-glottic suction tracheostomy tubes?

- Yes
- No
- Sometimes

28. Do you assist with identifying appropriate AAC on critical care?

- Never
- Rarely
- Sometimes
- Often
- Always

29. Are screening tools used for?

	Yes	No	Name/details of screening tools used
Communication			
Swallowing for post-extubated patients			
Swallowing for tracheostomised patients			

a. If screening tools are used, are these patients then referred appropriately to SLT?

- Never
- Rarely
- Sometimes
- Often
- Always

Page 5: Patient Management

30. Do you contribute to the following in your critical care units alongside your MDT?

	Never	Rarely	Sometimes	Often	Always	If you answered rarely or never, please state why
Tracheostomy weaning plans	○	○	○	○	○	
Ventilation weaning plans	○	○	○	○	○	

31. Do you use any of the following treatment techniques in critical care?

	Yes	No
Above Cuff Vocalisation	○	○
Facial Oral Tract Therapy	○	○
EMST	○	○
NMES	○	○
Pharyngeal Electrical Stimulation	○	○
sEMG	○	○
Swallowing exercises	○	○
Voice exercises	○	○

a. Are there any other treatment techniques that you use?

32. Are you meeting NICE CG83 guidance for therapy patients (45 mins per day, 5 days a week)?

○ Yes

○ No

a. If you're not meeting the NICE CG83 guidance, why not?

Page 6: MDT Collaboration

33. Do SLT attend any of the following in your critical care units?

	Never	Rarely	Sometimes	Often	Always
Morning handover rounds with the MDT	○	○	○	○	○
Ward rounds with the MDT	○	○	○	○	○
Trache rounds with the MDT	○	○	○	○	○
Weekly MDTs	○	○	○	○	○
Morbidity and mortality meetings	○	○	○	○	○
Quality or audit meetings	○	○	○	○	○
Clinical Governance meetings	○	○	○	○	○
Business meetings	○	○	○	○	○
Research meetings	○	○	○	○	○
Long-term patient meetings	○	○	○	○	○
Clinical incident meetings	○	○	○	○	○
Clinical guideline meetings	○	○	○	○	○

a. Are there any other meetings that SLT attend in your critical care units?

34. Are you a member of a Tracheostomy Team or a Tracheostomy Steering Group in your critical care?

Yes

No

35. Do you carry out audit or research on critical care patients?

Yes

No

a. If yes, is it collaborative research?

Yes

No

b. Please tell us about your research

36. Are you involved in teaching/training on your critical care units?

Yes

No

a. If you are involved in teaching/training, how often?

A few times per year

Once a month

A few times a month

Weekly

Other

i. If you selected Other, please specify:

b. If you're not involved in teaching/training, why not?

37. Are you involved in rehab prescriptions/weekly goal setting for critical care patients?

- Yes
- No

a. If you're not involved in rehab prescriptions/weekly goal setting, why not?

38. Are you involved in regional critical care peer review?

- Yes
- No

Page 7: Good Practice and Service Improvement

39. Do you have any data you would be willing to share showing the positive impact of SLT on patient outcomes in critical care?

- Yes
- No

a. If yes, please describe

40. In the last 2 years have your SLT critical care service and staffing levels:

- Improved
- Deteriorated
- Stayed the same

a. If your staffing has improved or deteriorated, please explain why?

41. If your SLT service is lacking, what risks does this present to critical care patients in your hospital?

42. Do you have any other comments?

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Thank you for taking the time to complete this survey. If you have any further comments or queries please contact Claire Mills (c.s.mills@leeds.ac.uk).

Appendix B: Survey Adverts

Twitter Advert

The @RCSLTTracheCEN committee are carrying out a survey investigating SLT service provision in critical care nationally. Please go to this link for more information and to complete the survey for your hospital/Trust #ICU #wespeechies:

[weblink to be inserted here]

Facebook Advert

The RCSLT Trache CEN committee are carrying out a survey investigating SLT service provision in critical care nationally. Please go to this link for more information and to complete the survey for your hospital/Trust:

[weblink to be inserted here]

The survey should take approximately 15 minutes to complete. Thank you.

RCSLT Bulletin Advert

The RCSLT Trache CEN committee are carrying out a survey investigating SLT service provision in critical care nationally. Please go to this link for more information and to complete the survey for your hospital/Trust:

[weblink to be inserted here]

The survey should take approximately 15 minutes to complete. Thank you.

Email to be sent to RCSLT Trache CEN distribution list and other contact lists

Dear Sir/Madam,

The RCSLT Trache CEN committee are carrying out a survey investigating SLT service provision in critical care nationally. The aims of this survey are:

1. To benchmark SLT service provision nationally

2. To identify factors which might explain differences in SLT service provision

3. To identify unmet needs and good practice

4. To inform recommendations for SLT staffing levels in critical care and feedback to the Intensive Care Society

Please go to this link for more information and to complete the survey for your hospital/Trust:

[weblink to be inserted here]

The survey should take approximately 15 minutes to complete. One survey should be completed for the paediatric critical care service and one survey for the adult critical care service per trust or hospital to avoid duplication.

If you would like any more information please contact Claire Mills on c.s.mills@leeds.ac.uk

Thank you for your time.

Kind Regards

The RCSLT Trache CEN committee: S Wallace, S McGowan, C Iezzi, A-L Sutt, C Mills, A Ginelly, V Thorpe, R O'Mahoney, C McDonald, E Probert

Appendix C: CHERRIES checklist

Checklist for Reporting Results of Internet E-Surveys (CHERRIES)[A]

Item Category	*Checklist Item*	*Explanation*	*Page Number and Description*
Design	Describe survey design	Describe target population, sample frame. Is the sample a convenience sample? (In "open" surveys this is most likely.)	Page 5: The survey targeted SLTs working in adult, paediatric and neonatal ICUs. Convenience sampling was used.
IRB (Institutional Review Board) approval and informed consent process	IRB approval	Mention whether the study has been approved by an IRB.	Page 4: Ethical approval was obtained from the University of Leeds
	Informed consent	Describe the informed consent process. Where were the participants told the length of time of the survey, which data were stored and where and for how long, who the investigator was, and the purpose of the study?	Supplemental Online Material (SOM) Appendix A: A participant information sheet was attached to survey to ensure informed consent. Survey completion took approximately 15 minutes. Data will be kept securely in University of Leeds for minimum of 10 years and anonymized data in a Research Repository. CM is the primary investigator (PI). The purpose of the survey was to establish the current status of SLT service provision to critical care patients in the UK. This was outlined in the participant information sheet on the first page of the survey.
	Data protection	If any personal information was collected or stored, describe what mechanisms were used to protect unauthorized access.	SOM Appendix A: This study complies with GDPR and DPA. Data is kept securely on University of Leeds network. *Jisc Online Surveys* is also secure and only accessed by username and password of the PI.
Development and pre-testing	Development and testing	State how the survey was developed, including whether the usability and technical functionality of the electronic questionnaire had been tested before fielding the questionnaire.	Page 4-5: The survey was developed on *Jisc Online Surveys*. Questions were developed by a group of SLT critical care experts to ensure content validity. The survey was piloted with 3

			external SLTs to test usability and technical functionality.
Recruitment process and description of the sample having access to the questionnaire	Open survey versus closed survey	An "open survey" is a survey open for each visitor of a site, while a closed survey is only open to a sample which the investigator knows (password-protected survey).	Page 4: Open survey.
	Contact mode	Indicate whether or not the initial contact with the potential participants was made on the Internet. (Investigators may also send out questionnaires by mail and allow for Web-based data entry.)	Page 4-5: Initial contact was made predominantly via the internet using social media and email. Only online submission of responses were accepted.
	Advertising the survey	How/where was the survey announced or advertised? Some examples are offline media (newspapers), or online (mailing lists – If yes, which ones?) or banner ads (Where were these banner ads posted and what did they look like?). It is important to know the wording of the announcement as it will heavily influence who chooses to participate. Ideally the survey announcement should be published as an appendix.	Page 4 and SOM Appendix B: The survey was advertised via SLT networks. Adverts were a mixture of social media posts and emails to members.
Survey administration	Web/E-mail	State the type of e-survey (eg, one posted on a Web site, or one sent out through e-mail). If it is an e-mail survey, were the responses entered manually into a database, or was there an automatic method for capturing responses?	Page 4-5: The survey was posted on *Jisc Online Surveys* and the link to this survey was sent out via the above methods.
	Context	Describe the Web site (for mailing list/newsgroup) in which the survey was posted. What is the Web site about, who is visiting it, what are visitors normally looking for? Discuss to what degree the content of the Web site could pre-select the sample or influence the results. For example, a survey about vaccination on a anti-immunization Web site will have different results from a Web survey conducted on a government Web site	Page 4: The survey was disseminated by SLT networks.
	Mandatory / voluntary	Was it a mandatory survey to be filled in by every visitor who wanted to enter the Web site, or was it a voluntary survey?	Page 5: Voluntary survey

	Incentives	Were any incentives offered (eg, monetary, prizes, or non-monetary incentives such as an offer to provide the survey results)?	Page 5: No incentives were offered.
	Time/Date	In what timeframe were the data collected?	Page 4: Data were collected over a period of 4 months from December 2018 to March 2019
	Randomization of items or questionnaires	To prevent biases items can be randomized or alternated.	Page 4: Items were not randomized or alternated.
	Adaptive questioning	Use adaptive questioning (certain items, or only conditionally displayed based on responses to other items) to reduce number and complexity of the questions.	Page 4: Adaptive questioning was not employed.
	Number of Items	What was the number of questionnaire items per page? The number of items is an important factor for the completion rate.	Appendix A: The number of items per page varied. Range: 4-13. Median 5 items.
	Number of screens (pages)	Over how many pages was the questionnaire distributed? The number of items is an important factor for the completion rate.	Appendix A: There were 7 pages.
	Completeness check	It is technically possible to do consistency or completeness checks before the questionnaire is submitted. Was this done, and if "yes", how (usually JAVAScript)? An alternative is to check for completeness after the questionnaire has been submitted (and highlight mandatory items). If this has been done, it should be reported. All items should provide a non-response option such as "not applicable" or "rather not say", and selection of one response option should be enforced.	Page 4: It was not possible to do a completeness check. *Jisc Online Surveys* does not provide an alerts for incompleteness. No questions were mandatory. Best practice for survey completion states that mandatory questions should be avoided where possible as they violate the voluntary nature of a survey[B].
	Review step	State whether respondents were able to review and change their answers (eg, through a Back button or a Review step which displays a summary of the responses and asks the respondents if they are correct).	Page 4: Respondents were able to review and change their answers through a 'back button'. There was no review step.
Response rates	Unique site visitor	If you provide view rates or participation rates, you need to define how you determined a unique visitor. There are	Page 4-5: In order to protect respondent anonymity, it is not possible to use cookies or IP addresses with *Jisc Online Surveys*. However,

		different techniques available, based on IP addresses or cookies or both.	the participants were able to 'finish later' and provide their details to come back to their survey. Therefore it is unlikely that any respondent would have completed the survey multiple times. This was confirmed by the demographic data (i.e. the name of the hospital and Trust) which demonstrated that there were no duplications of completion.
	View rate (Ratio of unique survey visitors/unique site visitors)	Requires counting unique visitors to the first page of the survey, divided by the number of unique site visitors (not page views!). It is not unusual to have view rates of less than 0.1 % if the survey is voluntary.	Page 5: Unable to calculate as unique site visitors not known.
	Participation rate (Ratio of unique visitors who agreed to participate/unique first survey page visitors)	Count the unique number of people who filled in the first survey page (or agreed to participate, for example by checking a checkbox), divided by visitors who visit the first page of the survey (or the informed consents page, if present). This can also be called "recruitment" rate.	Page 5: Participation rate was 11% (64/557). This calculation used page views rather than unique visitors and therefore this rate may be lower than if unique visitor count was used.
	Completion rate (Ratio of users who finished the survey/users who agreed to participate)	The number of people submitting the last questionnaire page, divided by the number of people who agreed to participate (or submitted the first survey page). This is only relevant if there is a separate "informed consent" page or if the survey goes over several pages. This is a measure for attrition. Note that "completion" can involve leaving questionnaire items blank. This is not a measure for how completely questionnaires were filled in. (If you need a measure for this, use the word "completeness rate".)	Page 5: Completion rate was 100% (64/64)
Preventing multiple entries from the same individual	Cookies used	Indicate whether cookies were used to assign a unique user identifier to each client computer. If so, mention the page on which the cookie was set and read, and how long the cookie was valid. Were duplicate entries avoided by preventing users access to the survey twice; or were	Page 4: Cookies were not collected (as explained above). Participants did have the option to 'finish later'.

		duplicate database entries having the same user ID eliminated before analysis? In the latter case, which entries were kept for analysis (eg, the first entry or the most recent)?	
	IP check	Indicate whether the IP address of the client computer was used to identify potential duplicate entries from the same user. If so, mention the period of time for which no two entries from the same IP address were allowed (eg, 24 hours). Were duplicate entries avoided by preventing users with the same IP address access to the survey twice; or were duplicate database entries having the same IP address within a given period of time eliminated before analysis? If the latter, which entries were kept for analysis (eg, the first entry or the most recent)?	Page 4: The IP address was not collected (as explained above). Participants did have the option to 'finish later'.
	Log file analysis	Indicate whether other techniques to analyze the log file for identification of multiple entries were used. If so, please describe.	Page 4: Log file was not collected for the same reasons as for IP addresses and cookies.
	Registration	In "closed" (non-open) surveys, users need to login first and it is easier to prevent duplicate entries from the same user. Describe how this was done. For example, was the survey never displayed a second time once the user had filled it in, or was the username stored together with the survey results and later eliminated? If the latter, which entries were kept for analysis (eg, the first entry or the most recent)?	Page 4: No registration required as this was an open survey
Analysis	Handling of incomplete questionnaires	Were only completed questionnaires analyzed? Were questionnaires which terminated early (where, for example, users did not go through all questionnaire pages) also analyzed?	Page 5: All data was analysed.
	Questionnaires submitted with an atypical timestamp	Some investigators may measure the time people needed to fill in a questionnaire and exclude questionnaires that were submitted too soon. Specify the timeframe that was used as a cut-off point, and describe how this point was determined.	Page 4: Timestamps were not recorded.

	Statistical correction	Indicate whether any methods such as weighting of items or propensity scores have been used to adjust for the non-representative sample; if so, please describe the methods.	Page 5: Statistical correction was not used.

[A] Eysenbach G (2004) Improving the Quality of Web Surveys: The Checklist for Reporting Results of Internet E-Surveys (CHERRIES). J Med Internet Res 6:e34. https://doi.org/10.2196/jmir.6.3.e34

[B] Dillman DA (1999) Mail and Internet Surveys: The Tailored Design Method, 2nd Revised edition. John Wiley & Sons, New York

Appendix D: Additional Data

Number of SLT referrals per month

The median number of referrals to SLT each month was 8.5 (range: 0 to 45). When adjusted for the number of critical care beds, the median number of referrals to SLT per bed, per month was 0.4 (range: 0 to 1).

Refusal to refer patients to SLT

Respondents reported that some members of staff refuse to refer to SLT (n=20/64, 31%).

Management by other staff groups

Sixty-nine percent (n=44/64) of respondents thought that other staff groups were managing patients that they thought should have been seen by SLT. Respondents from this 69%, reported the staff groups involved in patient management and the types of management are outlined in Table 1.

Table 1: Staff groups involved in managing patients that respondents believed should be seen by SLT and the types of patient management

		Number of respondents (%)
Professional group	Doctors	18 (41%)
	Dietician	1 (2%)
	Nurse	17 (39%)
	OT	2 (5%)
	Physio	27 (61%)
	MDT	4 (9%)
Type of patient management	ACV	3 (7%)
	Communication	4 (9%)
	PMV	11 (25%)
	Saliva management	3 (7%)
	Swallowing	15 (34%)
	Weaning	0 (0%)

Role of SLT within ICU MDTs

Eighty-five percent (n=55/64) of SLTs reported contributing to tracheostomy weaning plans and 61% (n=39/64) contributed to ventilator weaning plans to a greater or lesser degree. More specific break down of the frequency of contribution can be seen in Table 2.

Table 2 Frequency of SLT contribution to tracheostomy and ventilator weaning plans

		Number of respondents (%)
Tracheotomy weaning plans	Never	9 (14%)
	Rarely	10 (16%)
	Sometimes	18 (28%)
	Often	17 (27%)
	Always	10 (16%)
Ventilator weaning plans	Never	25 (39%)
	Rarely	19 (27%)
	Sometimes	11 (17%)
	Often	7 (11%)
	Always	2 (3%)

Participation in Tracheostomy teams/steering groups

Fifty-six percent (n=36/64) of respondents were a member of either a tracheostomy team or steering group.

Involvement in rehabilitation prescriptions/weekly goal setting on critical care

Forty-four percent (n=28/64) were involved in rehabilitation prescriptions/weekly goal setting.

Involvement in regional critical care peer review

Thirty-four percent (n=22/64) were involved in regional peer review.

Screening tools

Table 3 outlines the screening tools that respondents reported were being used in their ICUs.

Table 3 Screening tools used in ICU

		Number of respondents (%)
Communication screen	Yes	4 (6%)
	No	60 (94%)
Post-extubation dysphagia screen	Yes	18 (28%)
	No	46 (72%)
Swallowing screen for patients with a tracheostomy	Yes	9 (14%)
	No	55 (86%)

Subglottic tracheostomy tubes

Fifty-six percent (n=36/64) of respondents stated that tracheostomy tubes with a sub-glottic port were used in their ICU, and 22% (n=14/64) said that they were used sometimes.

SLT Rehabilitation techniques and incidence of use

Table 4 reports the various rehabilitation techniques that respondents reported were being used in their ICUs.

Table 4 SLT Rehabilitation techniques and incidence of use

		Number of respondents (%)
Above Cuff Vocalisation	Yes	32 (50%)
	No	30 (47%)
	No response	2 (3%)
Facial Oral Tract Therapy	Yes	15 (23%)
	No	46 (72%)
	No response	3 (5%)
Expiratory Muscle Strength Training (EMST)	Yes	3 (5%)
	No	57 (89%)
	No response	4 (6.25)
Neuromuscular Electrical Stimulation (NMES)	Yes	1 (2%)
	No	59 (92%)
	No response	4 (6.25%)
Pharyngeal Electrical Stimulation (PES)	Yes	2 (3%)
	No	59 (92%)
	No response	3 (5%)
Surface electromyogrphay (sEMG)	Yes	5 (8%)
	No	54 (84%)
	No response	5 (8%)
Swallowing exercises	Yes	58 (91%)
	No	6 (9%)