Decision time

Alison Newton and *Linzie Priestnall* engage their teams in a prioritisation process that takes into account clinical expertise, research evidence and national policy to ensure their adult inpatients receive a consistently fair speech and language therapy service.

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- HONE DECISION MAKING
- IMPROVE CONSISTENCY
- STRENGTHEN YOUR TEAM

On a daily basis we organise, interpret and combine a large amount of data when we prioritise our clients. However, this process is often intuitive and tacit. Newly qualified therapists need support to develop their skills in making priorities, and expert therapists also have a responsibility to reflect regularly upon their decision making.

Communicating Quality 3 (RCSLT, 2006) recommends that "a prioritisation policy should be formulated which defines a range of criteria upon which the decision to fulfil a duty of care will be made on a case by case basis" (p.139). It also states that, "The key factor in relation to prioritising an individual for therapeutic care is the judgement about the level of clinical risk" (p.140).

Figure 1 Moonlanding questionnaire (author unknown)

You are a space crew originally scheduled to rendezvous with a mother ship on the lighted surface of the moon. Due to mechanical difficulties, however, your ship was forced to land at a spot some 200 miles from the rendezvous point. During re-entry and landing much of the equipment on board was damaged and, since survival depends on reaching the mother ship, the most critical items must be chosen for the 200-mile trip. Below are listed 15 items left intact and undamaged after landing. Your task is to rank them in terms of importance in allowing your crew to reach the rendezvous point. Place the number 1 by the most important item, the number 2 by the second most important and so on through to number 15, the least important.

Ranking	Item
	Box of matches
	Food concentrate
	50 metres of nylon rope
	Parachute silk
	Portable heating unit
	Two 4.5 calibre pistols
	One case of dehydrated PET milk
	Two 100lb tanks of oxygen
	Stellar map (of moons and constellation)
	Life raft
	Magnetic compass
	5 gallons of water
	Signal flares
	First aid kit containing injection needles
	Solar powered FM receiver-transmitter

To produce a departmental prioritisation policy, we evaluated the system we use for prioritising our adult inpatient caseload. We led a process to enable our therapists to 'think aloud' their reasoning. This involved:

1. holding an individual short interview with each speech and language therapist, asking for their thoughts and concerns about the system they were using.
2. asking therapists how they would define a high, medium and low priority patient and to give some examples. The results across therapists were similar.
3. devising a data collection sheet, which was added to patients' case notes. Each therapist completed a tick box to identify the main factors that influenced their prioritisation decisions for each patient.
4. organising an in-service training session at which we asked staff to engage in:

a) a non-clinical decision making task to examine the process of decision making and how decisions are influenced (figure 1)

b) a discussion of the theory behind the process of decision making and the influencing factors in prioritisation (see Resources)

c) a clinical activity to collect information on how each therapist prioritised patients when given the same information (figure 2). This was designed to examine the consistency of decision making between different therapists and to create discussion of the reasons for each therapist's decisions, rather than saying who was right or wrong.

From this interaction and discussion we identified the factors (criteria) that influenced our decision making. We then considered which of these were acceptable and relevant and which were not; rather than individual factors, this usually related to the way they combined.

Template

The evaluation process provided a qualitatively rich information template on which to build our policy. We then looked at research papers, Trust policies and national guidelines for each criterion used to make a prioritisation decision to ensure that - as far as possible - we could support our decisions with evidence or a clear rationale.

We wrote a policy for prioritisation consisting of

- A definition of prioritisation
- A description of the department's system of prioritisation
- A flow chart for prioritising new referrals (figure 3)
- A list of guidelines outlining factors to consider when prioritising people with communication difficulties and dysphagia.

The system we operate uses a large whiteboard in the main speech and language therapy office (a room not used by clients or members of the public). This ensures that at any given time the entire patient caseload is visible for all therapists to view without compromising confidentiality.

The board is divided into seven sections; one for new referrals, one for each working day and one for messages. The names of patients and their ward number are written on the board on the day we would like them to be seen. Every day, each patient is given a relative priority rating of 1 (high priority), 2 (medium priority) or 3 (low priority). These are defined in the policy as patients who are:

1 - a priority for the day and require to be seen above those rated 2 or 3

2 - less of a priority but should still be seen that day

Figure 2 Prioritisation scenario

TODAY IS MONDAY.

Here are the new referrals (received on Monday morning) and the information you have about the patient. Based only on this information, place the patients in the order that you would see them.

Mr Smith
- Chronic Obstructive Pulmonary Disease
- Nil by mouth
- Has IV fluids in situ
- Alert
- Put nil by mouth on Sunday
- No nasogastric tube

Mrs Mouse
- Dementia – admitted with aspiration pneumonia
- Agitated – won't keep a venflon in for IV fluids
- No nasogastric tube
- Nil by mouth
- Alert and calling out for water
- Admitted on Sunday

Mr Carling
- Head injury
- Nil by mouth
- Nurse reports that patient is drowsy
- No nasogastric tube
- Has IV fluids in situ
- Admitted late Friday night

Mr Lawson
- New cerebrovascular accident
- Screened for dysphagia by nurse and passed
- Alert
- Unable to communicate

Mrs Pickering
- Patient reported to the nursing staff that food was sticking in her throat
- Alert
- Not nil by mouth

Mr Heath
- Multiple sclerosis
- Admitted Friday night with a chest infection
- Slurred speech
- Nil by mouth
- No nasogastric tube
- IV fluids in situ
- Alert

Our results from prioritisation task, with 1= highest priority and 6 = lowest priority:

	Mr Heath	Mrs Mouse	Mr Smith	Mr Lawson	Mr Carling*	Mrs Pickering
Therapist A	2	1	4	5	6	3
Therapist B	1	3	2	5	6	4
Therapist C	2	1	3	5	4	6
Therapist D	1	3	4	5	2	6
Therapist E	1	2	3	4	5	6
Therapist F	1	1	3	5	4	6
Therapist G	2	1	3	4	5	6
Therapist H	1	2	3	5	6	4

*Discussion around why Mr Carling was generally rated as a low priority but as 2 by another showed the importance of thinking about how information is written down. While most therapists thought the message about Mr Carling being drowsy was left on the Monday, hence lowering his priority, another assumed that the drowsiness related to the time of his admission on Friday and so he may now be alert.

3 - being monitored and not expected to require active / direct intervention.
New referrals are dated according to when we received the referral, and include information from the referrer pertinent to decision making, such as whether a patient is nil by mouth. In each case we are careful to make sure that decisions are made on the basis of clinical need and clinical risk. The receiving therapist allocates new referrals as low, medium or high priority and can use the flow chart (figure 3) for support.

When a patient has been seen, the therapist concerned wipes the patient's name from the current day and puts it back on the board on a different day with a priority rating. The priority is reconsidered on the basis of the input the patient has just received from the therapist. If a patient is not seen on the day allocated, their name is wiped off that day and put on the next, and the therapist considers whether this new situation means the priority rating should be higher.

Maintenance

In 2006 Linzie left our department to take a job at the Dudley Group of Hospitals NHS Trust.

We presented our system and policy to the speech and language therapy department there and the therapists decided to implement it. To date, the system has proved very successful in Dudley. Both of our teams continue to look at maintenance of the system with ongoing reflection on clinical decision making.

"How should we prioritise?" is not a new question. It's one we continue to ask, and that is a good thing. We don't claim to have solved the problem of how to prioritise, as the answer will always be constantly changing. But we now have a policy that will be evaluated and reviewed in the light of our knowledge, research, clinical experiences and national policy. We have also succeeded in engaging therapists in open dialogue within a supportive environment for evaluation and reflection on our complex and changing clinical framework.

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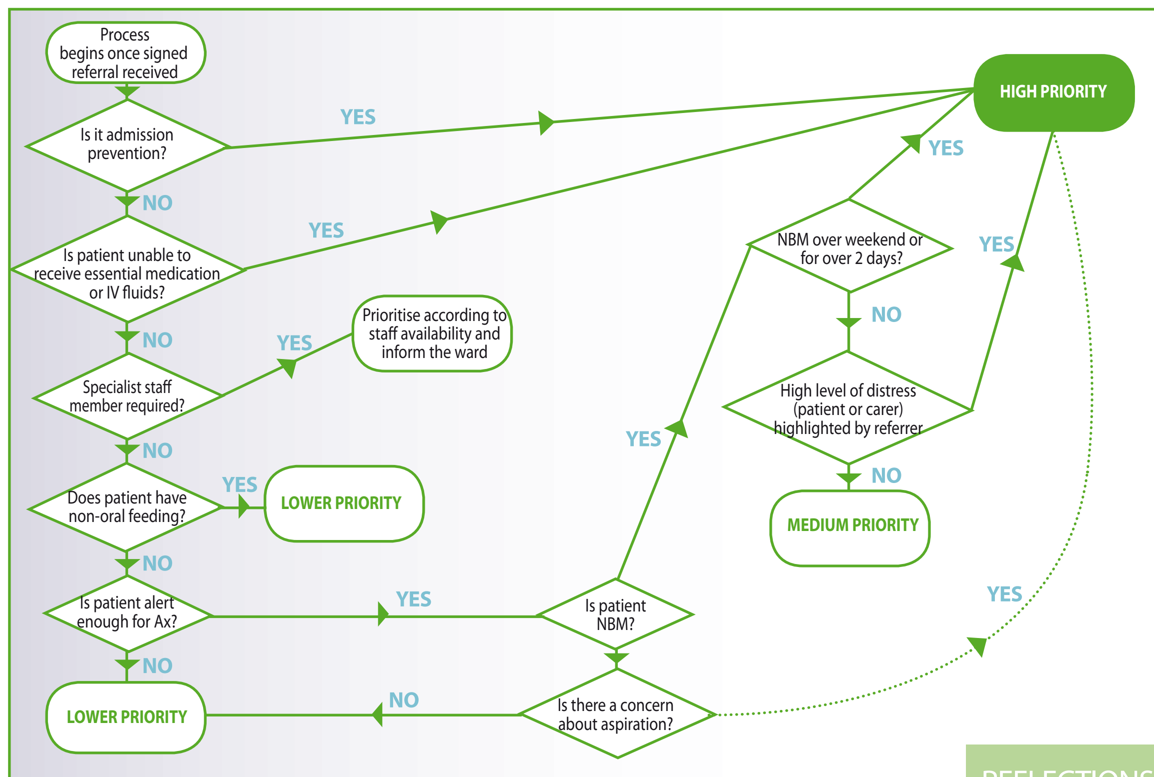
Figure 3 Flow chart for new referrals



REFLECTIONS

- DO I UNDERSTAND HOW DIFFERENT FACTORS CAN COMBINE TO RAISE OR LOWER PRIORITY?
- DO I HAVE AN OVERVIEW OF MY WHOLE CASELOAD AS WELL AS A FOCUS ON THE NEEDS OF INDIVIDUALS?
- DO I BALANCE MY TIME APPROPRIATELY BETWEEN CLIENTS WITH COMMUNICATION DIFFICULTIES AND THOSE WITH DYSPHAGIA?

How has this article been helpful to you? How does your prioritisation policy work?
Let us know via the Spring 08 forum at www.speechmag.com/Members/.

Reference

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