#TEXTTL Code A -Speech & Language Therapsi-Thursday

Recent arrival, experience in different care settlings.
Good standard referral system.
Solid supervision, training, structure.
Nothing unusual about ward, patient and relatives.
Tendency need for unilateral agreement.

Qualified 99
Portsmouth Health Trust August 99 at Q&A.
Oct 99 joined all adults group.
3 days at GWMH
2 days at Q&A
June 2001 Grade 2, Clinical co-ordinator for speech therapy for GWMH, day running, organisation, supervision of other staff.
Majority of work is outpatient.
50 inpatient.
Community work.

Training
- In-service training schemes
- Continued professional development – clinical case work, discussion groups every 2 months
- Discussion groups to talk about problems.
- Clinical observation groups, evaluations are conducted.
- Clinical co-ordinators meet twice a year. Meet with management at Gosport, meet about standards.

Link with MDT working
- Meeting on Daedalus ward Monday and Thursday.
- Attend meeting based on patients.
- No meetings attendance on Sultan and Dryad.

Share learning
- Provide in-house training ????? training – Daedalus management training.
- Sultan and Dryad will be invited for basic training.

Do all staff attend? Yes very enthusiastic about doing training. On one occasion – 12 months ago only 3 attend HCSW. Attendance is lower than expected due to staff issues, staffing levels too low to cover absence. Students and newly qualified will attend and shadow during their own work time. Attend before/after shifts.

Open referral system. If swallowing need a medical referral – Dr Yikena or GP Sultan. Appropriate in nature of timing? No inappropriate referral.

Problems with referral may leave patients unattended – nil by mouth. Will receive nutrition through subcutaneous, peg, nasal.

Admissions – speech therapist from discharged hospital will telephone ahead.

Service
- disvager/swallowing
- speech therapy 60/40
- work with patient and family, inpatients and outpatients

Relationship between relatives, patients and general staff. Sometimes meet family, depends on timing so may not see therapist. Does not create too many problems. There are some complaints about lack of therapy. This could be hindered due to medical reasons – no main reason for this happening.

Incidences of some tension between relatives and nurses where family are not happy but not on ward long enough to definitely confirm this.

Will try and contact relatives if they do not see them physically.

Expectations of death. Often patients status changes vastly. Very common that patients are not well enough for speech/language therapy. Assessed by speech therapist.

Disagreements about NG and Peg feeding.

Ethical decision will be made by Consultant and documented in medical notes. Discussion with family and Consultant and nurse grade. Issues around swallowing eg. patient who refused to eat although had swallowing problem but consultant wanted to peg speech, therapist would not. Late stage dementia – Consultant wanted peg feeding – therapist felt quality of life said no and family decided no. Decisions – no MDT meeting not necessarily unilateral decision.

Drugs – document what drugs patients are on.

Complaints. Complaint sheet, line manager and feedback mechanism.