

Applying Clinical Reasoning: a Caseload Management System for Community Occupational Therapists

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This article presents a system of caseload management for community occupational therapists. Using the clinical reasoning work of Mattingly and Fleming as a framework, the perceived complexity of each case for a community occupational therapist was analysed and then paralleled with the type and amount of clinical reasoning required.

Following an initial occupational therapy assessment, each case is given a numerical weighting, graded at 3 for complex cases and from 1 for non-complex or simple cases. The degree of complexity or weighting is recognised to be a subjective phenomenon dependent on the experience, knowledge and skills of the therapist. The cases held by an occupational therapist are able to be mixed so that the experienced therapist holds a varied caseload of complex and simple work. Beginning therapists can follow the same measured approach thus augmenting their background experience.

This method promotes continuing education, assists experiential learning and provides variety. Using this system, it is proposed that occupational therapy services are enhanced by reducing unnecessary casework from therapists' active caseloads, allowing increased time to work on complex cases and using expertise more efficiently.

Introduction

This article describes a working system devised to ensure appropriate quality (primarily) and quantity (secondarily) of casework interventions for clients as cases are opened up from the waiting lists of local authority occupational therapy departments. The system is hoped to facilitate a move away from a perceived tendency to deal with as many cases as possible in an adequate manner. It aims to provide a framework and a logic that will allow occupational therapists to effect therapeutic change that is holistic rather than just efficient from a resource perspective and/or that satisfies the basic legal requirements of service provision.

The initial development of the system began in 1991 by occupational therapists from the former Poplar Neighbourhood team, one of seven previously decentralised neighbourhoods of the London Borough of Tower Hamlets. The system takes into account the need for therapists to practise reflectively in respect of those cases that the authors believe come under the domain of concern for occupational therapy, namely complex multidimensional problems associated with occupational behaviour and/or performance.

Closely related to the ideals of providing a holistic service for clients is the need to develop staff knowledge, skills and reflective practice (Schön, 1987). The pressures of high waiting lists in many local authority occupational therapy departments have, in the opinion of the authors, resulted in therapists operating as waiting-list reducers or equipment and adaptation assessors rather than community-based therapists of occupation. The results of such pressures are evident in

(among other things) the importance attached to collecting statistics on the number of cases opened and closed or the number of adaptations performed rather than, for example, research concerned with clients' subjective perception of their changed and, it is to be hoped, enhanced occupational performance following occupational therapy.

For occupational therapists, the pressures of high waiting lists and staff shortages can result in very high caseloads, with inadequate quality and quantity of clinical supervision. Unpublished research focusing on the recruitment and retention of occupational therapists in the London Borough of Tower Hamlets highlighted that waiting-list pressures and high caseloads were of major concern to therapists with regard to job satisfaction and their retention within employment. The quality and quantity of supervision were also highlighted as being of major importance in relation to the retention of therapists (unpublished observations, Wilson, 1995).

A caseload weighting system, used as a tool to ensure quality occupational therapy services and to assist in staff development rather than (primarily) to ensure high case turnover, has been based on a framework developed within the area of clinical reasoning. The system is described following an elaboration of clinical reasoning as a fundamental aspect of our practice-based profession.

Clinical reasoning

Clinical reasoning is more than having a reason for an action. It is more than diagnostic and scientific deduction. Mattingly (1991) believes that clinical decisions are arrived at by far

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more than the application of theories from the biomedical world. She states that clinical reasoning is a 'largely tacit, highly imaginistic and deeply phenomenological mode of thinking' (p979). This thinking demands consideration of an individual's particular circumstances and the unique meaning of that circumstance for the individual or family. This is nicely related in the following statement:

Clinical reasoning in practice means reasoning not only about what is wrong and how to fix it, but also how to engage the patient in the fixing process. This in turn necessitates that the therapist understand enough about the meaning of disability from the patient's perspective, to develop a shared account of what fixing the problem would amount to in terms of their lives (Mattingly, 1991, p984).

Fleming (1991) proposed that therapists, without usually knowing it, use three different types of reasoning. She called this three-track reasoning. The three types are procedural, interactive and conditional. *Procedural* reasoning is grounded in the scientific method, involving thinking about procedures that might be used in alleviating a given condition. Being characterised by routine and protocol, procedural reasoning does not consider the person as a unique individual who has meaning attached to his or her situation. The consideration of meaning moves the therapist into the *interactive* mode of reasoning, which may involve straying from the 'correct' mode of working in an effort to understand the client as a person (Fleming, 1991). Speaking at the World Congress of Occupational Therapy in London in 1994, Munroe (unpublished observations) discussed interactive reasoning as, alternatively, a major strategy used by community occupational therapists to assist in negotiations, which may be employed particularly in problematic, sensitive and awkward cases. *Conditional* reasoning draws on aspects from a person's past and present, combining understanding from the procedural and interactive standpoints in order to consider the future. Conditional reasoning should result in decision making which looks to the future as derived from knowing (procedural) and understanding (interactive) (Fleming, 1991, 1994).

Schell and Cervero (1993) proposed that another type of thinking, called *pragmatic* reasoning, was an integral part of clinical reasoning. This considers constraints affecting reasoning, such as organisational and practice context, or resource availability. Neuhaus (1988) also discussed how, in the present economic climate, the individual needs of clients could not always be met. Pragmatic reasoning could therefore be seen as reasoning which aims to make the best possible decision within the situation as it is. Pragmatic reasoning may involve breaking procedure in order to effect what Aristotle described as a 'practicable good' rather than the 'ideal good' (Ross, 1985).

It is proposed that an ability to reason not only interactively and conditionally, but also pragmatically, denotes a difference between two phases of professional development in occupational therapists: the novice through to proficient therapist as opposed to the competent through to expert practitioner (Slater and Cohn, 1991). Drawing on Dreyfus and Dreyfus's (1986) original work on the development of expertise, Slater and Cohn (1991) outlined that novice, advanced beginner and competent practitioners still rely on facts and procedure and see situations as parts rather than wholes. Experience, and the opportunity and ability to reflect on this, moves the occupational therapist towards the complex and seemingly intuitive reasoning characteristic of the expert practitioner.

Occupational therapists do not generally graduate with an ability to reason in a manner most effective for some complex cases. Novice and advanced beginner therapists should be given the opportunity to consolidate procedural practice, in a

carefully graded manner, and then be gradually exposed to interactive, conditional and pragmatic considerations. Reflective practice ideally develops from the beginning of professional education and, once the therapist is employed, continues in a supportive, well staffed department, where discussing and reflecting on casework becomes as much a priority for effective outcomes as does going through the motions of the intervention.

Recognising complexity

Occupational therapists in Tower Hamlets Social Services do not use the standard Körner statistics protocol adopted by many of their health authority colleagues. The caseload management system that is described in this article is not about keeping statistics for management purposes. It is about each therapist and his or her supervising therapist becoming aware of the complexity of the cases open to them. It is about process rather than output.

Haylock and McGovern (1989) outlined a caseload management system which assigned a numerical 'weighting' to certain diagnoses and other variables, such as the numbers of visits required. Despite sharing some similarities with this work, the system described here bases case weighting on a subjectively perceived level of complexity which is dependent on the individual therapist's reasoning rather than that of the supervisor. Pre-assignment of a weighting to certain classifications of impairment and/or disability may compromise the interactive component of clinical reasoning, resulting in certain classifications of impairment being dealt with in a procedural or predefined manner.

Developing the system

The caseload weighting system in operation within Tower Hamlets Social Services was developed in response to a perceived pressure to open and close more cases despite having limited staff to do so. It became apparent that a well thought out document which outlined the department's conceptualisation of what constituted a 'complex' or a 'simple' case was required. The initial working party involved in the development of the system was unable categorically to relate complexity to certain types of diagnosis or to cases which, according to social services criteria, attracted an urgent priority for assessment.

As a starting point, three occupational therapists with more than 2 years' experience in social services settings analysed 70 cases. This represented the caseloads of two fieldworkers and a half-time fieldwork/occupational therapy manager. Each case was discussed in detail by all three members until the perceived aspects of complexity were teased out. Thus, the three therapists developed a 'feel' for the aspects that constituted a complex or simple case. The cases that each therapist perceived to be non-complex were characterised by a procedure or protocol. The cases perceived to be complex demanded complex or non-procedural reasoning. Typical comments by therapists involved in the process included: 'On paper this lady seemed to have real problems, but when I got there I was able to [adopt ... procedure] and we sorted things out fairly easily' or 'Things just didn't go according to plan with this one, there seems to be a new problem each week'.

Of major importance during the process was the realisation that cases could only be categorised as complex or simple following assessment and that the degree of complexity was specific to an individual worker and client. For example, one therapist had significant experience in working with clients disabled by architectural barriers and thus did not perceive complexities central to such cases to the same degree

as the other therapists. If a therapist is able to select and apply specific knowledge appropriate to the client's needs or has the experience to know intuitively when a certain procedure will be inappropriate and readily adopt another approach, the case may not, from that therapist's perspective, be complex. A different therapist may not as readily adopt or adapt his or her reasoning, particularly where procedures are a much relied upon guide. If procedures do not work and less logical thinking is called for, it is here that the complexity of a case rests.

Again, perception of complexity is a subjective experience dependent upon individual client circumstances and the therapist's knowledge, skills and experience. A particular therapist's ideal caseload cannot, therefore, be based on that of a colleague. This realisation is in line with a phenomenological approach, which considers the subjective realities of individuals rather than considering situations in a technical-rational way.

Several examples are given below, highlighting possible client characteristics which may necessitate a certain type of reasoning and, therefore, the degree of complexity. It must be emphasised that these client-dependent characteristics are only as complex as the type and amount of reasoning that is adopted by the therapist involved.

The caseload weighting document

The following section provides an explanation which is intended to be used as a guide and is not meant to be prescriptive. It describes the degree of complexity which is attached to certain cases following the initial occupational therapy assessment. Three categories are discussed: simple (quick or long) and complex.

Simple (quick)

- The worker is able to follow a set procedure.
- Minimal liaison is required with other departments, for example, housing (minimal interaction).
- Minimal documentation and/or technical drawings are necessary.
- The client's strengths/weaknesses present immediately, with solutions readily obtainable, requiring minimal interaction with the client. Only one or two short visits may be required (procedural reasoning).
- The client's occupational difficulties tend to be those that affect discrete tasks and, thus, do not affect the client's ability to perform a range of daily occupations.
- The client is satisfied with the intervention plan as devised. No revision or creative adaptation of the plan is required (procedural reasoning).

Example: Mrs A had difficulties getting on and off her settee and in and out of the bath easily. An assessment was performed, advice given, equipment ordered and simple works from housing requested. The case was put into a monitoring system where an occupational therapy assistant would phone or visit within 2 months, to ensure that all treatment and equipment recommended at the time of the assessment was still appropriate. The diagnosis was osteoarthritis.

Simple (long)

- Lengthy procedural tasks are required although the assessment and the intervention plan are readily completed (as above).
- Detailed technical drawings are required (perhaps with minimal deviation from standard).
- Specialist equipment is being awaited for trial and issue, with the expectation that such equipment will be appropriate for the client's needs (procedural reasoning).

- There are lengthy time delays due to multidepartmental involvement.

Example: Mrs G had problems with bathing. She was unable to manage with simple bath equipment and required an over-bath shower and a more supportive bath-board/seat (swivel bather). The diagnosis was multiple sclerosis.

Both the client and the therapist agreed that this was the only intervention required at this stage. Such a case might require slightly more specific drawings and would usually take over 3 months to complete, due to the involvement of and liaison between occupational therapist, housing surveyor and electrician. The trial of non-standard equipment might prolong the process, if it was not within the equipment store stock.

In general, the reasoning adopted for simple casework is procedural. The diagnosis, position on the waiting list or number of visits required does not necessarily make the case complex. If the reasoning required for the case is procedural, decisions can be made by protocol and the specifics of the situation will be familiar to the occupational therapist from his or her previous experiences. The therapist and client are readily able to devise a way forward. Multiple visits make the case lengthy but not complex.

Complex

- The problem(s) is not readily identified (procedural reasoning is inappropriate).
- The problem(s) is readily identified but not readily resolved (as above).
- There are difficulties with interaction, due to culture/language, conflicting interpretations of the problem (between worker and client or family) and/or the best way forward (interactive reasoning).
- There are changing conditions, usually complex because consideration of both the present and the future is involved. The client may not be thinking in the future, nor (realistically) in the present (conditional reasoning).
- There is a sudden disabling condition (perhaps involving news-breaking), which requires a very skilful mix of optimism on the part of the therapist in order to engage the client (motivation) and also a realism which does not jeopardise this (interactive and conditional reasoning).
- Rapport must be worked towards; this is potentially time consuming, but necessary.
- Multi-agency liaison is required; this becomes time consuming, particularly if other departments and/or services have conflicting criteria or procedures. It is in these circumstances that the occupational therapist must attempt to understand other professionals' reasoning. Interactive thinking is applied not only to the client but also to other service providers, such as housing departments, hospital therapists and home care workers.
- Technical knowledge must be applied very specifically because major housing, building, specialist equipment and technological considerations must be precise or must be different from what is standard. Frequent and lengthy liaison is required between surveyors, contractors, suppliers and, in turn, the client.
- Frustration caused as a result of seemingly unending negotiation without action requires careful and sympathetic interaction with the client.
- Providing various solutions on trial, having to appraise their value and then reassessing them can be a very lengthy process. For example, fine tuning of equipment or adjusting treatment programme details to individual needs must be followed through (interactive reasoning).
- Cases inherited from other occupational therapists are invariably complex otherwise they would have been closed

at the time of the therapist's departure. It is frequently difficult to understand another therapist's assessment, particularly if the documentation is not clear.

- In complex cases, documentation is a time-consuming procedure. The occupational therapy records must be valid in a court of law; they must not serve merely as a mental note for the therapist. The objective and subjective aspects of a client's occupational status must be fully detailed and supported.

Example: Master P had functional problems in all aspects of daily occupation: self-care activities such as feeding, toileting, hygiene and dressing; mobility and use of transport; enactment of student and worker roles; participation in familial and peer group roles; and use of and access to leisure options. The diagnosis was Duchenne muscular dystrophy.

This case represented a particularly complex situation for the occupational therapist involved, despite her having good paediatric knowledge and experience. The case demanded consideration of normal late-childhood/adolescent development and growth set within a condition which involved significant deterioration. Although some procedural aspects were present which might or might not be carried out by other staff, there were complex subjective considerations which affected the client's perception of the disability and/or handicap. The therapist used all her professional skills in order to enlist the interest and motivation of the client and family towards a future state. This allowed a fuller enactment of desired roles and the occupations associated with those roles. During times of particular stress such cases have the potential to demand virtually all of a therapist's working week, either in direct contact or in reflection and subsequent planning of a meaningful way forward. The diagnosis did not determine that the case was complex. What made such a case complex were procedures that were not always applicable and logic that did not always work. The therapist had to adopt a highly creative, imaginative and intuitive style of thinking.

The caseload document was written largely to provide some form of working guidelines for senior occupational therapists to refer to whilst supervising fieldworker occupational therapists. It is the opinion of the authors that analysis of the complexity of an actual case is a valuable supervision exercise which also facilitates reflective learning. The weighting of cases, as a joint process between therapist and supervisor, also serves to alert the supervisor to the workload pressure for the therapist as a result of not only case numbers but also the clinical reasoning demands of specific cases.

Numerical weighting

Each case that is thought to be 'complex' is given a numerical value set arbitrarily at 3. Cases thought to be 'simple' attract a numerical value of 1, with extra points added for length. If an occupational therapy assistant takes over the follow-up or guided reassessment of lengthy cases then the occupational therapist becomes the supervisor of that case and this is given 1 point. An occupational therapist's total monthly numerical value is thus negotiated between the worker and the supervisor. Based on the initial analysis of the three Poplar occupational therapists, the following preliminary points were negotiated and are offered here, as an example only, of one negotiated caseload.

For an occupational therapist with over 5 years' experience, who is working full time and perhaps also supervising one other occupational therapist or an occupational therapy assistant although not an occupational therapy student, a caseload of 40 points was agreed to be a reasonable workload. This agreement was based on the fact that each member of the working party perceived a reduced ability to offer anything other than a procedural service to clients as his or

her caseload crept beyond approximately 40 points. It was felt that 40 points was the maximum number because these experienced occupational therapists may be involved in management as well as the casework, or they may have significant clinical supervision commitments, thus decreasing the overall time for casework. Case points are therefore less than 40 for more inexperienced therapists, but may also be less for those experienced therapists carrying out many duties unrelated to their own clients.

Negotiating the mix

Within the total individually agreed caseload allowance, occupational therapists can also negotiate the proportion of complex to simple cases they have on their caseload, as long as the total point value does not exceed the agreed workload. This offers the supervisor a creative method for allowing for therapist interest, experience and learning opportunity. It can also take into consideration changes in client or therapist circumstances, such as working as a fieldwork educator or altering the number of hours at work.

Outcomes

No formal evaluation has been conducted thus far regarding the system. In the process of preparing this article, a reorganisation within Tower Hamlets Council has meant that seven formerly decentralised neighbourhood teams have been re-centralised into two east/west teams. The system is currently in use in both teams, involving four senior practitioner occupational therapists (clinical supervisors) and fourteen fieldworker occupational therapists. Informal feedback highlighted subjectively perceived positive benefits, such as steadily decreasing workloads for therapists felt to be seriously overburdened and at risk of ineffective practice; more focused supervision sessions; and more analysis of interactive considerations which may have been previously disregarded as irrelevant by the therapist. Evaluation of the system, which commenced in only one neighbourhood, can now be undertaken readily in the two larger teams.

The planned research will adopt a qualitative methodology, with in-depth interviews to be conducted with fieldworker and senior practitioner therapists. This methodology is suitable because it addresses the subjective realities of the therapist's experience of the complexities of his or her casework, and his or her own stage of professional development, in relation to the system.

Applicability for use with occupational therapy assistants

The system was not devised with consideration for use with occupational therapy assistants. Despite this, a very logical view of the role of occupational therapy assistants becomes apparent. It is the authors' opinion that, although many assistants are using considerable reasoning skills, this should not be an expectation in relation to complex casework. Further, it is the authors' opinion that initial holistic assessments, as opposed to reassessment of one-off task difficulties, should not be carried out by assistants. This would mean that the issue of 'weighting' a particular case for occupational therapy assistants does not arise.

This does not dispute the fact that occupational therapy assistants are a very necessary part of the service, but suggests that, in general, they should be responsible for carrying out aspects of simple and complex casework rather than the assessment of such. For example, following the identification of solutions to simple or complex cases, or the finalisation of treatment programme details by the occupational therapist.

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the occupational therapy assistant may carry out the procedural aspects.

A caseload weighting system for occupational therapy assistants requires extra thought which is not dealt with in this article. This would acknowledge the importance of the development of knowledge and skills for occupational therapy assistants, without whom the treatment recommendations advised by occupational therapists would remain unmet.

Conclusion

The caseload weighting system, based on a framework developed from clinical reasoning research undertaken in occupational therapy, recognises that it is the thinking and reasoning process involved in intervention which determines the complexity of a case. Further, cases that are complex for one occupational therapist are not necessarily complex for another. It is proposed that this system will allow occupational therapists the opportunity to reflect on and articulate the nature of a clinical situation, such that the complexities of subjective and pragmatic issues can be taken into account creatively before cases are closed. The development of competence and expertise based on reflective practice can be given the priority it deserves. A service that develops a reputation for such an employment environment can only win a larger share of the limited supply of occupational therapists and provide the recipients of occupational therapy services with a thorough and holistic service.

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