The Dimensions of Interprofessional Practice

"Being Interprofessional is about collaborating in ways that are fit for purpose"

(Hammick et al, 2009 p.11).

This paper reflects on a specific experience of interprofessional working encountered while in clinical practice, and critically analyses and evaluates the extent to which interprofessional collaboration has enhanced a patient's journey. For the purpose of reflection the commentary is written in the first person. In accordance with the Nursing and Midwifery Code (2009), confidentiality shall be maintained and all names have been changed to protect identity. Gibbs' reflective cycle (1988), will be used to help guide the work. Gibbs' (1988), framework (Diagram 1) is a seminal theory on reflective practice (Jasper, 2003). This cycle contains six stages including a description of the event, discussion about feelings encountered, evaluation of the positive and negative aspects of the experience, analysis of the event, conclusion of the overall experience and finally an action plan to prepare should the experience be encountered again. The unique role and contribution that nursing makes within the interprofessional team will be discussed.

The effectiveness of contributions of all team members in providing holistic care to a patient will be drawn upon. Decision making, problem solving processes and ethical elements associated with interprofessional practice will be discussed and reflected upon to explore how how these aspects might influence my clinical practice and decision making. Recommendations for future practice are made.

Description:

The first stage of Gibbs' reflective cycle (1988), focuses on a description of the event. The following introduces the patient and relevant history. Throughout this commentary the pseudonym of Mrs Jones is used. She was a 48 year old lady who I looked after over a period of 4 weeks. She presented in 2004 with breast cancer in her left breast and multiple bone metastases, treated with Tamoxifen, a hormone treatment used for patients with breast cancer.

Tamoxifen interferes with the activity of oestrogen, which can promote the development of breast cancer. Tamoxifen lowers the risk of breast cancer recurring or developing in the other breast (Cancer research UK, 2009).

In 2009 Mrs Jones was found to have cancer of the right breast and underwent a mastectomy followed by chemotherapy. Alongside this she was diagnosed with spinal cord compression which was treated with radiotherapy.

Diagram 1: The reflective cycle (Gibbs 1988)

Mrs Jones was admitted to the accident and emergency department with complaints of painful ears, frontal mild headache, dizziness, vomiting and left sided weakness. Following investigations she was found to have multiple brain metastases. She was transferred to an oncology ward and underwent palliative radiotherapy. She was made aware of her life expectancy which was less than six months.

Mrs Jones lived with her husband and 8 year old daughter. Her mother now lived with them to assist her with all activities of living (AL's), however her mother had her own health problems. Mrs Jones was aware of her prognosis and was keen to return home as soon as possible.

To fully support Mrs Jones whilst in hospital the nursing process was initiated in order to enable a problem solving approach to nursing care (Yura & Walsh, 1967). This provides a systematic way of holistically examining a patient's needs with a view to resolution. Holistic care recognises the uniqueness of each human being and their individuality (Makinen, 2003). The concept requires the nurses to think beyond cure and concentrates on the delivery of individualised care. Offering support holistically to Mrs Jones would promote feelings of well being and allow her to make decisions about future interventions. It is imperative that this approach is adopted by health care professionals and implemented during the assessment and care planning process (Hamilton & Price, 2007).

The Roper, Logan and Tierney (2000), model of assessment was used with Mrs Jones as part of the nursing process based on activities of daily living. While undertaking the assessment, key nursing skills such as effective verbal and written communication were applied. This is vital in obtaining an accurate assessment and highlights interventions needed for individual patient care (Holland et al, 2008). Following assessment it became evident that Mrs Jone's needs were centred around mobility, personal cleansing, hygiene and her emotional state. This initiated a decision making process to formulate a plan of care from information obtained from the assessment. This process involves communication which starts with deciding to do something and establishing what action to take. It involves decision making and problem solving and results in an individual communicating a course of action to someone else (Niven, 2006).

In order to offer full support, ensure appropriate interventions and seamless care to Mrs Jones it was imperative that collaboration with members of the multidisciplinary team (MDT) took place involving different health and social care professionals to widen a collective understanding and efficient coordination, a flattened hierarchy and transformational leadership (Lethard, 2003). The important role played by the nurse in the interprofessional team is recognised by the government in its document 'Modernising Nursing Careers' which

describes nurses as taking responsibility for care co-ordination, standards of care and leading the nursing workforce as part of the MDT (DH, 2006). .

Mrs Jones was referred to a Physiotherapist and Occupational Therapist (OT), as due to disease progression she had suffered a left sided weakness causing unsteadiness and a lack of confidence. The Physiotherapist assessed Mrs Jones and decided on a best plan of treatment to assist with movement, balance and overcome weakness of her limbs. The OT introduced daily tasks and educated her on alternate ways to complete them. The OT was also responsible for assessing Mrs Jones' home during preparation for her discharge. Obstacles within the house such as steps, chairs, beds and toilets were assessed and appropriate action to overcome these issues were determined. This included the introduction of a riser/ recliner chair, commode, wheelchair and ramps to allow Mrs Jones to enter and exit her property safely.

Following the home visit a referral to the discharge team was completed by the nursing staff to aid in coordinating a safe and timely discharge from hospital and to social services. Social services offer support and services at home, via a care package to aid with assistance, personal care, transferring and toileting. Having this support at home would allow Mrs Jones to be cared for in her home environment and remain with her family.

To address Mrs Jones and her family's psychological needs the nursing team initiated a Palliative Care Team (PCT) referral. This team has expertise in improving quality of life of patients and families facing life threatening illness. This includes assessment, treatment of pain and other physical problems alongside psychological and spiritual needs (NHS, 2010). The PCT team suggested referral to a counsellor to provide extra support for Mrs Jones and her daughter. The counsellor offered advice on coping strategies to help them manage the terminal illness. A referral to the Community Macmillan team was completed by the nursing team to provide continuity of support from the PCT following discharge.

Feelings:

The second stage of Gibbs' reflective cycle (1988), is related to feelings aroused during an event. The following explores my role within the interprofessional team and how I feel the team worked in collaboration to enhance Mrs Jone's journey.

Key elements in helping Mrs Jones maintain a level of independence, acceptable quality of life and a safe discharge from hospital included co-ordination and effective, person centred teamwork. Veitch & Christie (2007), state "teamwork is working together in a way which involves cooperation and understanding". This is only effective if a group takes a collaborative approach and has the capacity to experience and manage conflict, risk and stress understanding how their individual behaviour not only affects others but has an impact on the overall team performance. The dynamics of a group are an important influence on the success of goal achievement and member satisfaction (Arnold, 2007).

In the team I felt a sense of group identity and efficiency. We collectively believed that we would do well and worked as a group rather than as individuals. (Balzer Riley, 2008). As a student nurse I felt valued within the team. The nursing role in the interprofessional team was a key co-ordinating and communication role and I often observed team members employing the nurse as a centre point for information. Henderson (1966 cited in McCabe & Timmins,2006) discusses the role of the nurse as the person who 'knows' the patient and employs all other disciplines in organising care. Although this statement acknowledges that caring for patients requires an interprofessional approach it also suggests the nurse develops stronger relationships with the patients than other health care professionals as they provide 24 hour care.
It is only through good communication and the development of the relationship that nurses can identify the needs of their patients and therefore the nurse has a possible greater advantage than other team members in understanding individual patient needs and requirements (Miers & Pollard, 2009).

As one of the nurses coordinating Mrs Jones' care I acted as her advocate, one of the explicit roles of nursing. I took this responsibility seriously and felt that Mrs Jones trusted me (NMC, 2009). The ethical aspect of advocacy gives the nurse's role an important dimension to patient care. As Mrs Jones nurse I was responsible for protecting her health and well being and was accountable to her. Advocacy involves protecting patients from other health care professionals if their actions could potentially endanger the patient and cause significant moral harm (Fry & Johnstone, 2002).

<u>Evaluation:</u>

The third stage of Gibbs' reflective cycle (1988), encourages exploration of the experiences both positive and negative encountered throughout the event.

Communication is an essential part of the nurse's role. This is evidenced by the Benchmarks of best practice in communication which emphasise the importance of ensuring the nurse provides effective communication sensitive to patient's individual needs (DH, 2007). Good communication and collaboration was evident in the overall involvement of the interprofessional team, enhanced by team members regularly and clearly documenting their care of Mrs Jones in her medical notes. Medical notes are a plan where health care professionals communicate with each other and collaboration occurs (Philpin, 2002). Documentation of care is vital and a legal requirement for a nurse as it promotes communication and sharing of information between members of the MDT (NMC, 2009). This is also a requirement of other disciplines as stated in their codes of professional conduct (College for Occupational Therapists 2005; The Chartered Society of Physiotherapy, 2005). It was important to document clearly what was happening to Mrs Jones as it was likely this would help promote high quality care (Balzer Riley, 2008).

Mrs Jones' progress and care was also communicated during the nursing staff handover where the incoming shift were informed of her treatment, care plans and care priorities. Nurses were encouraged to read Mrs Jones medical notes to ensure they had up to date information on input from other disciplines to provide a thorough handover. A thorough handover of Mrs Jones' care maintained her safety and continuity of care (Tucker, 2009).

To enhance interprofessional working and ensure appropriate care, a multidisciplinary team meeting was arranged which I attended. It was held without Mrs Jones present and this allowed all members of the team to discuss her care without fear of distressing her. Face to face communication allows non verbal signals to be picked up and immediate responses to be made, enabling better understanding and effective group communication (Sheldon, 2004). Unless professionals communicate well with each other they are unlikely to be effective in their interactions with patients and relatives (Dougherty & Lister, 2005). For a team to successfully perform it is vital that all members are involved in the problem solving and decision making process (Webster, 2002).

This organised meeting included the ward clerk who took minutes of the meeting. The PCT consultant acted as facilitator, a function to keep the group focused on the task and to enable team members to reach their optimum level of performance (Napier, 1999). Other members included Doctors, Physiotherapists, OT, Counsellor, two ward Nurses and the Discharge Co-ordinator. The meeting gave individuals a chance to discuss their contributions to Mrs Jones care. Unfortunately the Social Worker was not available resulting in crucial information being omitted and Mrs Jones discharge delayed. This is discussed further in analysis.

The meeting involved a shared decision making and problem solving process. Nurses and other health care professionals make numerous decisions when caring for patients. Shared decisions allow for enhanced input, the ability to deal with more complex problems and result in better decisions being made (Sullivan & Decker, 2005). This shared decision making process was also applied with Mrs Jones to allow her greater choice in her care.

The interprofessional team included professionals with varying levels of training and experiences. Diverse points of view were discussed and listened to resulting in the team implementing an agreed plan of care in the best interest of Mrs Jones.

Analysis:

The fourth stage of Gibbs' (1988) cycle is where one can "break things down into their components parts" (Jasper, 2003) and analyse what went well and what didn't during an event. In Mrs Jones' case there was a delay in discharge as we waited for a care package to be put in place. This was frustrating for all team members as all worked collaboratively towards a fast effective discharge. On analysing this event I feel this was due to a number of reasons including the Social work team being absent at the MDT meeting and annual leave creating reduced levels of staff. Hornby & Atkins (2000), discuss how failure to establish adequate lines of communication for continuing collaboration, particularly where feedback is important is frequently the cause of a patient receiving poor care and delayed discharge. There are often barriers to interprofessional collaboration due to various factors such as professionals lack of understanding of colleagues roles and their work priorities.

Knowledge of member's roles is important in appreciating the constraints under which they work. It can help identify shared goals and help develop appropriate ways of joint working.

Joint work is imperative as it helps avoid misunderstandings (Meads, 2005). A lack of clarity about the scope of the responsibilities attached to roles performed by various members can be a source of conflict within interprofessional teams (Thompson et al, 2000).

Knowledge and skills of various professions portray a wide range of academic disciplines who work within a professional framework to formulate thoughts and actions. Different professionals inevitably provide their own views and work within their own frameworks to formulate thoughts and actions. Frameworks are an important element in professional identity. Within these there are similarities and differences in the professional values and ethical frameworks that practitioners in different professions work towards. For example the NMC, (2009) refers to a patient's uniqueness, whereas the Social Workers code of practice (2002), refers to group as well as individual differences (Hammick, 2009).

The interprofessional team working in alignment with their different codes of conduct will also have an impact on their care priorities. The Doctor's primary focus is the patient's medical care and they carry legal responsibility for most decisions about this care. The Social Worker's priority is also the patient but the family or social context may be equally important and can result in social workers priorities differing from medical priorities (Thompson, Melia & Boyd, 2000). Mrs Jones case may not have been priority for the Social Worker, therefore was not assigned to anyone else in her absence. During the case conference the Discharge Co-ordinator was able to contact the Social Services Team and this enabled them to allocate another member of staff to attend to Mrs Jones' case but not without incurring a delay.

In the case of Mrs Jones, coordination and efficiency of her care was excellent and the involvement of each member had a helpful impact on her journey. The Doctor's decision to give Mrs Jones a course of palliative radiotherapy reduced her symptoms and promoted confidence. The input from the Physiotherapy team helped Mrs Jones mobility with the aid of a Zimmer frame, enabling her mobility over short distances. Input from the OT allowed Mrs Jones independence in hygiene needs and prepared her for home. The support from the PCT team and counsellor allowed Mrs Jones and her family to find strategies to cope with her poor prognosis and prepare them for discharge. Care and support were in place at home from the Social Worker and the nursing team coordinated all preparations for discharge including booking transport, having medication ready to take home and ensuring Mrs Jones was aware of all services and support available on discharge. This allowed Mrs Jones and her family to

feel well supported and prepared. Overall I felt a part of this team and gained a positive experience of interprofessional working which will enhance my professional practice. This experience has allowed me to become more self aware, discovering how individual behaviours influence internal and external events and how individual responses affect others and the importance of good communication not just with patient's and relatives, but within a team to prevent barriers to optimal care. I feel I have an improved understanding of the roles of others and of how to work effectively as part of a team. The roles of responsibility, accountability, and communication were clear leading to effective collaboration, enhanced continuity of care, co ordination of care, discharge planning, integration of services and overall seamless care to Mrs Jones.

The final stage of Gibbs' (1988), cycle is action plan (Diagram 2) to prepare should a similar experience be encountered again.

Conclusion:

Throughout this commentary it is evidenced that the unique role and contributions of the nurse are important elements within the interprofessional team. Nurse's aid co-ordination and communication within the team therefore the importance of good communication skills needed to provide holistic care have been demonstrated (Holland et al, 2008).

The effectiveness of individual members in a team has been highlighted and group dynamics explored, in particular the impact of these on the performance of the team. Working in a team has allowed me to be aware of the importance of other professional roles and how differences in their codes of conduct can affect team working. The success of a team depends on individuals sharing the same goal and their ability to remove barriers and promote effective collaboration (Lethard, 2003).

Decision making and problem solving processes related to Mrs Jones case have been discussed. Clinical decision making is an integral aspect of the nurse's role and impacts on patients care and the actions of other health care professionals. Understanding this will help enhance my team working and improve patient care. In using Gibbs' (1988) reflective cycle I have learned from this experience. Recommendations for future practice have been made. Although Mrs Jones discharge was delayed, the overall experience has made me aware that

barriers can be encountered but also overcome in an interprofessional team approach. Having reflected on interprofessional working I now feel more prepared in clinical practice to be an effective member of the interprofessional team.

ACTION PLAN			
Issues requiring specific intervention	**Goals in relation to the issues**	**Methods to achieve goals**	**Methods**
Communication skills within interprofessional team.	To improve on my communication skills to ensure I enhance interprofessional working.	Gain more experience in interprofessional working. Be a willing and skillful communicator with other members of the team.	Gain feedback from colleagues to ensure my communication skills
Gain an in depth knowledge and skills of other members roles in the interprofessional team.	In any practice area I work, ensure I understand all the roles of interprofessional members, to ensure continuity of care and alleviate barriers.	Work alongside other members. Communicate with individuals to gain an understanding of their role and responsibility for individual patients care.	To gain knowledge and experience of each members role by work patients. Attending MDT meetings will allow me to gain an in dep
Gain confidence.	To improve my confidence.	To communicate more with team members. Gain experience and knowledge in order to feel confident when liaising with interprofessional members.	To demonstrate willingness and displaying an approachable attitu enhance my learning and improve my knowledge therefore I will g

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